

THE MEDICAL JOURNAL OF AUSTRALIA

VOL. I.—30TH YEAR.

SYDNEY, SATURDAY, JANUARY 2, 1943.

No. 1.

**Supplies Now
Available**

‘IODOLYSIN’

Trade Mark.

IN RHEUMATISM & RHEUMATOID ARTHRITIS

“Iodolysin” is a soluble compound of Thiosinamin (43%) and Iodine (47%), used as a fibrolytic agent for the removal of pathological fibrous tissue.

It has given strikingly successful results in the treatment of many cases of rheumatism, rheumatoid arthritis and arthritis deformans. Good results have also been reported from the use of “Iodolysin” in the treatment of strictures, pyloric stenosis and arteriosclerosis. Physicians are invited to write for leaflet giving full particulars and details of treatment.

PREPARATIONS.

“AZOULE” “IODOLYSIN”, for Hypodermic Injection, min. 15 and min. 30; in boxes of 12.

“KAPSOL” “IODOLYSIN” Gelatine capsules for oral administration: each contains 2 grs. “Iodolysin”; boxes of 40.

“IODOLYSIN” SOLUTION for oral administration: 1 oz. and 2 oz. bottles.

“IODOLYSIN” OINTMENT for local application: 1 oz. tubes.

“IODOLYSIN” PIGMENT for local application: 1 oz. bottles.

ALLEN & HANBURY'S (AUSTRALASIA) LTD

41 HUNTER STREET, SYDNEY

Pioneer Vitamin Preparations

Time and money ungrudgingly spent on research work and on perfecting the manufacturing process have made Roche Products Limited the pre-dominate manufacturers of vitamin B₁, C and E.

B₁ 'BENERVA' VITAMIN B₁

(Aneurin Thiamin Chloride). Now a substance of major importance in dietetics, 'Benerva' Vitamin B₁ has a wide field of application in therapeutics. Essential to carbohydrate metabolism. Specific in beri-beri. Valuable in neuritis of varying aetiology, trigeminal neuralgia, migraine, pain in varicose ulcers, trench foot.

Preparations: 'Benerva' Tablets in 20's, 100's and 500's. Ampoules, 1 c.c. in 6's, 12's and 50's, and 'Benerva' Forte Ampoules in 3's, 12's and 50's.

B₂ LACTOFLAVIN 'ROCHE'

(Riboflavin, Vitamin B₂, Vitamin G). An important member of the vitamin B complex. Plays an essential part in sugar and fat metabolism. Given in sprue, steatorrhoea and coeliac disease. Lactoflavin lowers blood sugar in diabetics; has a detoxicating effect in poisoning by heavy metals. Of value in allergic conditions and night blindness.

Preparations: Lactoflavin Tablets 'Roche' (1 mg.) in 20's and 100's. Ampoules, 2 c.c. (1 mg.) in 6's.

NICOTINIC ACID 'ROCHE'

(Pellagra-Preventive Factor). Specific in the treatment of pellagra; also used in sprue and some forms of glossitis and stomatitis.

Preparations: Tablets (50 mg.) in 100's and 1000's.

C 'REDOXON' VITAMIN C

(Ascorbic Acid). Large doses advisable in infectious conditions, and for promoting wound healing, in the treatment of peptic ulcer, fractures, stomato-gingivitis, etc. Increases sulphanilamide and arsenobenzol tolerance.

Preparations: Tablets (50 mg.) in 20's, 100's and 500's. Ampoules, 2 c.c. (100 mg.) in 6's and 50's.

'Redoxon' Forte Ampoules (500 mg.) in 3's and 25's. Powder in bottles of 1 gm. and 25 gm.

FURTHER DETAILED INFORMATION ON THE ABOVE PREPARATIONS AND ON OTHER VITAMINS, e.g. 'EPHYNAL' VITAMIN E, and 'SYNKAVIT' VITAMIN K ANALOGUE ON REQUEST.



Manufactured by:

ROCHE PRODUCTS LIMITED

WELWYN GARDEN CITY, HERTS., ENGLAND

Australian Agents: F. H. Faulding & Co. Ltd., 98 Castlereagh St., Redfern Park, Sydney, New South Wales.

THE MEDICAL JOURNAL OF AUSTRALIA

VOL. I.—30TH YEAR.

SYDNEY, SATURDAY, JANUARY 2, 1913.

No. 1.

Table of Contents.

[The Whole of the Literary Matter in THE MEDICAL JOURNAL OF AUSTRALIA is Copyright.]

ORIGINAL ARTICLES—	Page.	CORRESPONDENCE—	Page.
An Address, by H. Boyd Graham, D.S.O., M.C., M.D., F.R.A.C.P.	1	The Allied Works Council and Civilian Medical Practitioners	21
Experiences of Salt Deficiency, by J. M. Flattery	5	NAVAL, MILITARY AND AIR FORCE—	
Potato Diet in Peptic Ulcer, by L. J. J. Nye, F.R.A.C.P.	7	Appointments	21
REVIEWS—		Casualties	21
A Book on After-Treatment	8	OBITUARY—	
Development of the Child	8	James Adam Dick	21
LEADING ARTICLES—		THE ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS—	
Discussions on a General Medical Service for Australia	9	Examination for Membership	22
CURRENT COMMENT—		CORRIGENDUM	22
Sprue	10	NOMINATIONS AND ELECTIONS	22
Index to "The Medical Journal of Australia"	11	MEDICAL APPOINTMENTS	22
ABSTRACTS FROM MEDICAL LITERATURE—		AUSTRALIAN MEDICAL BOARD PROCEEDINGS—	
Therapeutics	12	South Australia	22
Neurology and Psychiatry	13	BOOKS RECEIVED	22
BRITISH MEDICAL ASSOCIATION NEWS—		MEDICAL APPOINTMENTS: IMPORTANT NOTICE	22
Annual Meeting	14	EDITORIAL NOTICES	22
PUBLIC HEALTH—			
Parliamentary Joint Committee on Social Security	16		

An Address.¹

By H. BOYD GRAHAM, D.S.O., M.C., M.D., F.R.A.C.P.,
Retiring President, Victorian Branch, British
Medical Association, Melbourne.

It is a great pleasure to see Dr. John Cahill in the presidential chair. I offer him my congratulations and best wishes. He brings to his office many years of experience of participation in the affairs of the Branch, and there cannot be many general practitioners in the State of higher standing in the respect and regard of their colleagues and their patients.

In February, 1941, it was a sad blow to us all when our then President, Dr. A. E. Coates, had to leave us for active service abroad; and it became my fate to act here in his stead. We had the great joy of seeing him back amongst us at the end of his term, but he had to depart again on the very eve of delivering his address a year ago, and the address was read by Dr. H. C. Colville. To our great sorrow, Dr. Coates and many another of our members became prisoners of war after the fall of Singapore, and we have no present news of them. I wish to record my sympathy with them and their relatives. Others have made the supreme sacrifice and we have added their names to our roll of honour. Some of our number are still in the thick of the fighting, and our thoughts are with them; and some, we are happy to say, have returned to us.

My term of office has been a long one, and we have had many very thorny problems before us. Your attention is directed to the details recorded in the annual report. I am under a debt of gratitude to the members of the Executive and of the Council, and to Dr. C. H. Dickson and his office staff. My duties have been made considerably easier by the support I have had from them all.

The matters of chief concern to the members of the Council of the Branch during the past two years have been three in number. The first has been to support the authorities in every way possible to provide suitable and sufficient medical officers for the armed services; the second has been to maintain a service for the civilian community which would cover, so far as possible, the gaps caused by the removal of many of the most active and capable members of the medical profession; and the third has been to consider the future of the profession in the light of the development of new ideas about the needs of the community. The trend is towards a regimentation of the profession and the setting up of some system of practice as a public utility.

It is unnecessary to say very much about the first of these matters, because the whole world knows that the medical services for the navy, army and air force are splendidly manned and have given an excellent account of themselves in every theatre of war and throughout the length and breadth of Australia.

The needs of the civilian community have been met by the operation of the machinery set up for the express purpose of selecting medical men for the services with due regard to the minimal requirements of the civilians. It would be presumptive on my part to do more than draw your attention to the outstandingly successful way in which the Central and State Medical Coordination Committees have operated. It may not have been realized by you all that not only has the pool from which medical personnel has to be drawn been used for the main medical services, including the auxiliary women's services, but it has also been necessary to find full-time medical officers for many other community activities, such as the Munitions Department and the Allied Works Council. It has also been a matter of policy to take into the services every able-bodied young graduate, so that those who have been left to conduct private practice have not had their numbers kept up year by year from that source, and have had to stand the incidence of illness and death which has not been by any means inconsiderable. The situation has given us all deep concern.

¹ Delivered at the annual meeting of the Victorian Branch of the British Medical Association on December 2, 1942, at Melbourne.

We cannot escape the conclusion that many have died or broken down in health because of the excessive strain of the conditions under which they have been working. Many of those who have remained in civilian practice are also doing part-time work for the services. Their devotion to duty has been wonderful, and the avoidance of a breakdown in an essential service is a matter for hearty commendation and deserves public acknowledgement. The Emergency Medical Service has helped by controlling the movement of doctors. Through its agency some men who were able to be detached from fixed areas have been distributed to act as *locum tenentes*. A few licensed refugee doctors have been placed in practices here and there, chiefly in country districts which would otherwise have been left without doctors. Through the courtesy of the directors of the army and air force medical services we have also been able to get short-term assistance from doctors here and there who could be spared from their posts for that purpose.

Admittedly, these problems of the supply of personnel for the services and for the community have been difficult, and are becoming increasingly difficult as time goes on; but those difficulties are as nothing in comparison with the problem of reconstruction and the wise use in the future of the manifold benefits of medical knowledge as a contribution towards a sane, happy and healthy nationhood. It is probable that we shall not all be able to continue to practise our profession individually and independently. What, then, is our future to be?

Ye who listen with credulity to the whispers of fancy, and pursue with eagerness the phantoms of hope; who expect that age will perform the promises of youth, and that the deficiencies of the present day will be supplied by the morrow; attend to the history of Rasselas, prince of Abyssinia.

It is the privilege of a retiring president to attempt to express his personal views on a question of outstanding professional interest, and in what is to follow it is imperative that it shall be understood that what is said is a personal view only.

We have been confronted with evidences from many quarters to show that many people in influential positions consider that some form of nationalization of the medical profession is essential.

The Federal Council of the British Medical Association and the Branch Councils in all the States have had under discussion a series of schemes purporting to show various ways in which that objective could be achieved. It is already apparent that there is an absence of unanimity in the selection of one scheme rather than another. Even if the Councils concerned, after profound and extensive debate, managed to evolve a plan acceptable to them all, it is extremely doubtful whether the individual members of the profession, now in civilian practice or holding commissions in the services, would accept the plan without many protests. My reason for coming to that conclusion is that those of our number who have not taken part in the discussions are so busily wrapped up in their present avocations that the scheme would descend upon them as a novelty and would be bound to be bristling with controversial points. It may be argued that such an attitude is an absurd one to adopt, because of the paramount importance of the requirements of the community over the private interests of members of the profession; but it is axiomatic that the well-being of the community and of the members of any profession in that community run along parallel lines. The medical profession, at all events, has made a notable contribution to the community's welfare during the war, and can be relied upon at all times to serve the people well. The members of the profession can be trusted to supply by private initiative a medical service designed to meet the needs of the community without any fear that they will exploit the situation selfishly or unfairly.

Let us now consider some of the outstanding features of the present civilian medical service as it is carried on, largely by private enterprise, and partly by full-time departmental medical officers.

In a broad way the non-departmental doctors may be grouped as follows: (a) those who are general prac-

titioners; (b) those who are regarded as specialists, because they limit the scope of their service, displaying a pronounced leaning towards their special subjects. Many of the "specialists" are known as "consultants"; but it is unusual in this State for them to restrict their activities to purely consultant work. Indeed, quite a number of those in general practice are able and anxious to show such particular interest in a special subject that their colleagues refer patients to them and consult with them. Fortunately also it is not unusual for general practitioners to meet each other in consultation. The prevailing system, then, is one in which there is a considerable intermingling, and it is very difficult to draw a line of cleavage between general practitioners and specialists. It is probable that there is a more distinct separation between surgeons and physicians; that separation has been accentuated by the formation of the Royal Australasian Colleges of Physicians and of Surgeons.

We are all proud of the very high standard of medical education in the State; the only medical school is at the University of Melbourne. The curriculum is extremely generous, and every graduate has to satisfy the examiners in all subjects. For at least fifty years our graduates have been recognized throughout the English-speaking nations as high-class products who have enjoyed a remarkably sound all-round training. When doctors of other training schools and other countries come among us, we realize that the same cannot be said of all medical schools. We find among them men and women who have had such a meagre education in surgery that they have not had any opportunity to develop surgical judgement and cannot attempt to perform operations; or they have been trained so intensively in some speciality or other that they are quite unsuited for general practice. We are satisfied that the policy of our own medical school is sound; it makes it obligatory for all to be trained for general practice, leaving specialization for those who seek it later on. It may be debatable whether it will continue to be economical to adhere to that policy. It may be considered wasteful to train students in all branches of medicine and surgery if it is intended that they should devote their lives to work in a corner of the field only. I have been impressed by the reported successes of limited training in Russia in connexion with the staffing of the social services, particularly for women and for children. Perhaps, if the foundation of a senior school course in the biological sciences were present, men and women could be successfully trained for obstetrics or for the management and care of infants and children, and for such surgical specialties as orthopaedics or eye work or ear, nose and throat work. The holders of such qualifications might be good enough for the needs of the community; but it is unquestionable that they would not be so good as fully trained persons.

So far I have been reviewing the classes of doctors who are practising privately. I have not referred in the same way yet to the large number in our midst who are occupying departmental positions and in that sense may be said to be practising publicly. In our State, almost all of these public medical practitioners have been trained in our own medical school, in which it is necessary to undertake a complete study of all branches of medicine and surgery. The standard of education, then, is just the same as that of the private practitioners. After they have joined a departmental medical service, however, the restriction of service is definite and the subsequent training is limited to the requirements of the office held. After a few years of occupancy of a position in a department, the medical officer becomes highly efficient in his special work, but relatively unable to give it up and go into general practice. In that sense his all-round utility is comparable with that of some of the private practitioners who confine their work to a narrow speciality.

I have been attempting to make out a case for the recognition of the fact that in the medical service which is at present available to the public at large, private doctors and departmental medical officers are as a rule well trained and highly skilled.

It is difficult to convince me that there is any need for a great upheaval and revision of the medical service. I am convinced that the doctor who is practising privately, by his enterprise and keenness for his professional work, gives more of himself and his time to the service of the community than is customary in any of the public services. The regulations and conditions of work in any public service limit the scope of the service of the individual doctor, and there is a tendency to restrict the time to office hours. The money incentive to enterprise almost disappears in a departmental service, because the salaries are varied from time to time only under the compulsion of mass demand. The natural increase in income which one is entitled to expect with the ripening of experience and the passage of time depends mainly on promotion, and it is not unnatural for men to feel a grievance if promotion by selection of a younger man occurs instead of promotion by seniority; that question creates grievances, which detract from efficiency and the broadening of the mind.

It is all very fine for a successful person, who has had the good luck to make his way to the top or to be selected for an important position over the heads of his envious fellows, to point out with satisfaction the advantages of being in a departmental service. We should rather consider the situation of the average person in the service, who may have to spend the whole of the prime of life in a relatively junior appointment. He will be a man equal in ability to those who trained with him and qualified at the same time, but elected to pursue the path of private enterprise. He will find his contemporary in private practice enjoying a position of prominence, perhaps in the very suburb in which he himself lives. The private practitioner will have a larger income and be more widely known and appreciated as a prominent citizen, while he himself has to see his family grow up at a disadvantage economically and socially because he has to cut his cloth according to the measure—and he knows in advance just how limited are the cloth and the measure.

Surely thinking members of the general public can have nothing to gain by making us all departmental medical officers. Such an action would reduce the scope of the service and usefulness of those of its own members who have shown ability and undergone the considerable amount of self-denial required to fit themselves to be private medical practitioners. Each of them has earned the gratitude and respect of countless hundreds of people to such an extent that he has become their guide, philosopher and friend. Each of them is regarded as a man or woman of independent thought and worldly wisdom, who has formed the life-long habit of study, and who by virtue of his strength and independence of mind can bolster up the mental and physical weaknesses of those who come to him for help. I, for one, should hate for a wage to sell health across a counter to my clients. More than three-quarters of my interest in my profession would be taken from me by such a retrograde state of affairs.

There is in existence today a large number of private contracts between practising doctors and the managements of the friendly societies and lodges to provide for their members a medical service of limited scope in return for quarterly payments on a *per capita* basis. There is also quite a lot of talk concerning the manifold advantages of an extension of that type of medical benefit. It has even been advocated that a compulsory insurance scheme should embrace all wage-earners in receipt of moderate wages, payments being made on a *per capita* basis, and contributed by wage-earner, employer and government. Others have gone further still, and seem to think that the government should pay the lot, provide a free medical service for a majority (if not all) of the people of the community, and pay the doctors salaries to do the work. It appears to me that many laymen fall into the serious error of making themselves believe that free doctors for everybody would abolish ill health. Doctors are only human beings after all, and medicine is not an exact science. In my humble opinion it is almost certain that the effect would be reversed.

Members of friendly societies and lodges should be able to testify that they are not kept free from ill health, even

for the payment of £1 per family per year. It is my further opinion that under the prevailing conditions of contract practice of the type under discussion, many of those entitled to the benefits are reluctant to exercise their right to the pound of flesh, and fail to consult the doctor in the early stages of what turns out later to be a mortal or disabling complaint. There are also some beneficiaries who never lose an opportunity of obtaining what is practically free medical advice for every trifle, and make a regular nuisance of themselves, and waste the doctor's time. If perchance one of those happens to drift into a serious complaint, he may share the fate of the shepherd lad, who used to cry "Wolf, wolf!" to make fun of his neighbours.

There also seems to be a notion abroad on which is founded the belief that no measures concerning preventive medicine enter into the scheme of things in private practice. Of course, nothing could be further from the facts. In his everyday work the doctor is the centre for dissemination of reliable information for the adoption of preventive measures. The real thing that limits our usefulness in this field is our impotence to remove the root causes of illness. The root causes of illness include bad housing, insufficient money to buy enough suitable food in a land where plenty of it abounds, and failure to regulate conditions under which people have to work. The eradication of causes such as those seems to be a legitimate governmental function, and a boldly progressive policy would certainly provide rich dividends in the form of better national health. A wise government would make greater use of advice on these questions, which could be obtained from well-informed members of the medical profession.

It may be said that people of my vintage are sufficiently well established in the existing system to be biased against the vaunted benefits of a radical change in the system, and that younger doctors should decide the issue for the profession. I dispute that attitude strongly. The younger people have not had time or opportunity to be in so strong a position to form opinions based on varied experience, and they may be so sanguine in their outlook that they would be convinced by specious promises of improved conditions and less strenuous work, and of more holidays and an assured pension on retirement. Those promises may turn into wormwood. In the attempt to achieve an easier way of living (and of dying), those who are prepared to assist a government to inflict upon an unsuspecting public a salaried medical service for all, to the exclusion of private practice as we know it, are in grave danger of selling their birthright for a mess of pottage. Esau did that when he was a young man and rued it when he was older!

Let us rather examine the ways in which the existing system can be made to meet the requirements of the present and the immediate future. Let us follow the evolutionary plan of developing what is good and eliminating what is bad, to go from where we are to where we want to go. And let us go there by our own devices, before a plan not of our own making is thrust upon us.

One recognizes that, from the layman's point of view, the risk of being ill is a financial hazard of such magnitude that it is capable of upsetting economic plans for quite an appreciable proportion of the community. This proposition is capable of many solutions. Obviously, the most desirable one is that the sickness should be much less expensive. Another one is that those who are prudent enough to insure against the risk, may do so in some business-like way that is not the concern of the doctor—provided that the insurance fund is sufficiently solvent to pay for the sickness. In my opinion, the combination of these two solutions is the sound one. In other words, the doctors should bring down the costs of sickness by more highly organized methods of conducting practice. Employers, municipal and governmental authorities and other interested parties could stimulate the establishment of medical pools to pay the lowered costs.

I believe that in the metropolis and in some country towns doctors should practise in groups. They should of their own initiative provide suitable accommodation for the group to practise at a site conveniently situated for

the patients. That central building should be equipped for investigational requirements and treatment including minor surgical procedures. Collectively, they should provide technicians to do as much as possible of the non-medical but time-consuming work. The doctors should be consulted about the amount and kind of accommodation needed in hospitals in the area of the group practice. Between them they should organize the group, whether in a large centre or in a small one, in such a way that they could undertake almost all classes of medical and surgical service.

Of course, a private "specialist and consultant" service would still be required.

Travelling expenses to cover loss of time of doctors practising in the country fall heavily on individual patients. This charge could be minimized by the utilization of civil ambulance services at rural centres. By the use of an ambulance to take a patient to a doctor, more efficient medical service would be obtained and the doctor's time would be saved. A somewhat similar system would be a great convenience in the suburbs too.

Doctors should be prepared to close their ranks and work in harmony with each other. And they may have to be satisfied with a lower average net income.

I cannot see any reason why the framework of such a scheme should not be constructed now, while the war is still on.

The State Medical Coordination Committee is in possession of a great deal of information concerning the required distribution of medical practitioners, and it might be asked to indicate the suitable zones for future group medical services. The central points could be at suitable distances from each other to provide for a much more rational spread of doctors than obtains at present. Speedy transport over the excellent road surfaces makes it unnecessary to have doctors located close to their patients.

At present, while the number of doctors available for the community is insufficient for comfortable practice and adequate time off for holidays, and while it is out of the question to leave one's practice for courses of post-graduate study, all the advantages of group practice would not be garnered during the war. When that happy time comes and the war is over, the gaps in the groups could be filled by careful selection of returning medical officers to fill vacancies. As the teams become completed, the system of group practices could be elaborated, and extra technicians and clerical and nursing assistants would be available too.

If the Commonwealth Government decided to introduce a simple health and pensions benefits scheme, exclusive of medical treatment, it would be feasible for contracts to be made on a "fee for service" basis with the private owners of group practices or with individual doctors to provide the medical treatment.

It should be the function and privilege of governmental bodies to facilitate the proposed new system of group practices in every way possible. One outstanding contribution would be to recognize capital expended on their development as a legitimate deduction for income tax purposes. Another would be to provide accommodation for chronically ill and convalescent patients, at pleasant, restful and healthful spots in the country. The Department of Public Health might well be expanded to dovetail in with the preventive activities of the private practices, and to supply additional preventoria and sanatoria of various kinds. Additional antenatal and child welfare clinics would be needed either at private or at public centres.

I believe it would be an improvement if the hospitals were completely under unified direction. That direction could be most effectively exerted through a hospitals commission with a statutory charter and the necessary funds. Central direction and local management should be the policy. The out-patient departments at public hospitals as we know them should be modified considerably. What is needed is provision for the reception of casualties and prospective in-patients. Facilities should, of course, be provided for the obtaining of consultant opinions. It would be much more satisfactory for the present out-patients to obtain advice and treatment at group centres. I think that the staff of the public hospitals, including the medical

officers, should be engaged and paid under regulations by the commission. Visiting medical officers should receive payment on a sessional basis. They should be replaced whenever their services were not considered to be of the required high standard of efficiency. It might even be advisable to have comparatively frequent changes, so that each private practitioner would have the opportunity to occupy a part-time position in the service of the hospitals commission for a few years. By that arrangement the government would have some control over the training of doctors, not only in the undergraduate stage, but also after their graduation. Members of the residential medical staff could expect reasonable conditions of service and payment for work done. Some of them would remain in the service of the hospitals commission sufficiently long to specialize in the work. The general level of efficiency of medical superintendents would rise throughout the State. In the network of hospitals under the direction of the hospitals commission, treatment could be given to the families of indigents and of low-wage earners. It would be found necessary to provide accommodation for those of moderate means at intermediate rates.

Amazing progress has been made in Victoria in recent years. Fine modern hospitals have been established throughout the country. More are needed in the suburbs. All but the really indigent should be expected to pay for services rendered, either as individuals or as participants in a contributory scheme.

Small private hospitals are rapidly disappearing in the wake of small private schools; many of them are obsolete and are doomed. Existing hospitals under the control of the Victorian Bush Nursing Association and hospitals under the aegis of bodies such as the religious denominations, the Salvation Army and the friendly societies, must be retained. They should be incorporated in the scheme as voluntary hospitals. The present management of voluntary hospitals should not be seriously disturbed. The hospitals commission should, however, be empowered to set standards of efficiency in management and insist on the maintenance of requisite standards of accommodation, charges and service. The nature of the illness and treatment rather than the economic position of the patient should be the factor determining the admittance of patients and the type of accommodation and service provided.

The whole of the operations of the hospitals commission should be closely linked with those of the Department of Public Health on the one hand, and with the private group practices on the other. Great attention would need to be paid to the very important subject of midwifery. I do not believe that a parturient woman can be safer in her own home than in a properly conducted midwifery centre. If the average private home is regarded as better than the existing hospital accommodation, we must advocate measures for the improvement of the institutions. Midwifery must remain an important part of the work of general practitioners, and each of them must have a thoroughly reliable midwifery hospital close at hand.

A weakness in our present system is a lack of regular health examinations, particularly for children and adolescents. The staff of the medical service of the Department of Education is altogether too small numerically to undertake anything significant in this field. If it is to continue in existence, the service must be expanded considerably, both in staff and in scope of work. Physical examination alone is insufficient. Behaviour problems should be investigated by experts at a sufficiently early stage in their development for the application of remedial measures. It is a moot point whether such a project should remain a function of the Department of Education. It would probably be better to make it a responsibility of municipal and shire councils. Those bodies would no doubt make use of the local medical talent available; but they might see fit to set up a full-time service headed by a municipal health officer especially trained for the purpose, and expected to devote the whole of his time to it. He would probably be an officer of the Department of Public Health, and would engage assistants on suitable terms including reasonable payment for work

done. A special feature of the municipal health service should be the care and management of babies and children of pre-school age, and it should cover physical and mental hygiene, including formation of nursery kindergartens and play-groups and the provision of suitable grounds, buildings, equipment and trained staff. The local municipal authority is, in my opinion, the right one to organize proper standards of housing and food, and he might well undertake the job of supervising "physical fitness for all", taking a fatherly interest in tennis, cricket, football, swimming and golf, and fostering the formation of local branches of all healthful youth welfare movements, including clubs for boys and for girls.

I hope I have said enough to make it plain to everyone that members of the medical profession have a very important role in my conception of national reconstruction. I contend that though departments should be considerably strengthened in medical personnel, and municipal health measures should be extended, there still remains a definite scope for the persistence of private medical practice. But the system of private practice must be much more highly organized than it is at present. There are in our ranks many men and women already qualified by experience to lead the way in the work of organizing; and many of them are not members of a Branch Council of the British Medical Association. Some have made considerable progress towards establishing private group practices; others have devoted a great deal of time to ideal planning; practically every doctor now practising privately has had considerable experience in planning his day's work to advantage. And soon we hope there will be hundreds of medical officers coming back into practice from the armed services, with minds broadened and sharpened and trained as a result of participation in professional teamwork of a highly organized nature. There are those within the profession itself who have expressed the opinion that those returning medical officers would welcome the availability of a national medical service, into which they could slip, and in which they could settle down to a life of regimented, salaried existence. I am advancing the view that even if this were a part truth, those same returning officers would much rather be fitted into privately organized group practices.

I trust that the incoming members of the Branch Council will do me the honour to consider seriously the main substance of this address, and if it is found that sufficient of them are of my way of thinking, there is important work ahead of us. We shall have to select a planning committee to evolve model outlines for private group practices of assorted types to supply the essential requirements of communities of differing sizes and geographical and sociological distribution. We shall need a well-informed propaganda department to survey the areas and make local arrangements, and also to obtain publicity for our activities over the air and in the Press. And we shall need an organization fund sufficiently large to cover the additional expenses of those activities. If most of the members are genuinely and enthusiastically anxious to provide a greatly improved medical service, I implore them to canvass all the potentialities earnestly and thoughtfully, to avoid the likelihood of the establishment of a government-controlled, all-in service for the whole community. If it is to be the unfortunate lot of the medical profession to be nationalized, I think that payment by salaries would be better than payment on a capitation basis; and if practically the whole of the profession is to be involved, I should prefer the scope of service to be as broad as possible in the interest of the community.

If a health insurance scheme comes to fruition, I hope that it will be entirely separated from legislation dealing with payment of benefits for loss of employment through accident or sickness or unemployment and with pensions for invalidity and old age. I heartily hope that the Commonwealth Government will abandon the national health and pensions legislation of 1937 and 1938 and make a fresh start to provide generous subsistence allowances for children without supporters, for invalids and cripples, for those who have lost employment through accident or sickness, for the unemployed, and for those who have not

been able to provide enough during their last few years. These allowances should be claimed as rights under specified conditions; but every attempt should be made to encourage rehabilitation in the community and withdrawal of the allowance.

I am firmly convinced, however, that those matters should not be confused in the same legislation with payment of doctors in a health insurance scheme; that is an entirely different subject. If a separate national health insurance scheme is introduced, the plan of the Federal Council of the British Medical Association commends itself to me with few reservations. In that plan, however, there is no arrangement for the method of payment of the doctors, though it can be inferred that *per capita* payments are envisaged. For over a year now, in New Zealand, "general medical services" have been within the scope of the health benefits under the *Social Security Act*, 1938, on the "fee for service" basis of payment of the doctors. That system is now running concurrently with the capitation system which was previously introduced. The "fee for service" system, if satisfactory in New Zealand, will, I hope, become our policy if the Commonwealth Government favours the plan of the Federal Council of the British Medical Association in Australia.

Whatever is to happen to us, I have the utmost confidence in the Council of the Victorian Branch and its office bearers; and I shall continue to do what I can to assist in their deliberations and activities.

Let us all, like Rasselas, "be fired with the desire of doing something though we know not yet with distinctness either the end or the means". "He had before been terrified at the length of life which nature promised him because he considered that in a long time much must be endured"; but, when fired with the desire of doing something, "he now rejoiced in his youth because in many years much might be done".

EXPERIENCES OF SALT DEFICIENCY.

By J. M. FLATTERY,

Surgeon-Commander, Royal Australian Navy,
Sydney.

THE following experiences of cases of illness following exposure to a high atmospheric temperature, the illness being attributed to a salt deficiency due to its loss through excessive and profuse sweating, extend over a period of approximately two years.

I shall deal with the subject on the following lines: (i) an outline of the working conditions, (ii) reference to the types of illness encountered, (iii) prophylactic measures, (iv) comment and conclusions.

Working Conditions.

With regard to the conditions under which we worked, we had long periods of service in the tropics abroad, interrupted by dashes into the other extreme of cold. A rating's description of the state of affairs was as follows: "We at least get variation in climate, cold and shivering one week wrapped up in duffel coats and balaclavas, the next week sweating our 'guts' out and overdressed in a pair of tropical shorts." No doubt I have omitted an odd word or two from this description. With this rapid change of temperature there is little chance of becoming acclimatized.

It is the white races unaccustomed to tropics who are specially susceptible to the effect of heat exposure, the natives of tropical countries are rarely affected unless some complicating disease is present.⁽¹⁾

The tropical climate encountered was the usual, hot, humid, windless, enervating one; superimposed on this are the conditions prevailing on ships during wartime. From sunset till after the completion of "dawn action stations", "darken ship" is the prevailing order; all scuttles

are closed, deadlights are dropped and the hatches are closed down, the result being that all natural ventilation is completely cut off. The same conditions prevail also when an enemy report is received, and the ship goes into the first degree of readiness for action. This state may last for many days.

The places where cases of heat exhaustion are most likely to occur are the engine rooms and the boiler rooms. The ventilation of the engine room is produced by fans and exhaust, and in the boiler room there are forced draught and exhaust fans. In the engine room, the movement of air caused by the fans is not complete; in some positions to which ratings have occasionally to go, the air is in a more or less stagnant condition. The average temperature in the engine room is 117° F., while in certain parts it may rise to 125° F. The exposure to these high temperatures is prolonged, an important factor in the causation of heat stroke, and it need scarcely be emphasized that what is involved is not merely an exposure to high temperatures; the ratings are actually working under these conditions, and it is universally accepted that exertion is an important predisposing cause. "Heavy physical exertion in temperatures over 110° F. is very dangerous."¹⁰ It is stated also that a condition of ill health is a predisposing cause of heat stroke; but this does not apply to patients seen on board. Those affected were healthy and fit prior to succumbing to the effects of heat; it was the conditions enumerated above, with no other factors, that caused the attacks.

Actually, even at rest (and apart from personnel working in the engine and boiler rooms), every person has periods of profuse and continuous sweating.

Types of Illness Encountered.

The types of illness caused by exposure to a high temperature are classified as follows: (i) heat exhaustion, (ii) heat hyperpyrexia (heat stroke or sun stroke), (iii) gastric types of illness, (iv) gastro-intestinal types of illness, (v) heat cramps. All types of cases were encountered except the second (heat stroke or sun stroke).

The following is a typical example of heat exhaustion:

Stoker T.M., aged nineteen years, was brought to the sick bay in a state of collapse. There was a history of vague abdominal pain and vomiting during the previous two days, but examination had revealed no abnormality. Prior to his admission to sick bay, the abdominal pain had suddenly become acute, causing further attacks of vomiting; this was followed by giddiness and collapse.

On examination, the patient was very pale and was sweating profusely; the skin was cold and clammy to touch. The pulse was rapid in rate (110 per minute) and weak, the temperature was 97.4° F. and the respirations were increased in number. Tenderness was elicited on deep pressure in the right iliac fossa; no rigidity was discovered, but there was some muscle guarding. No tenderness was present on rectal examination.

The clinical picture with the history of previous abdominal pain and localized tenderness in the right iliac fossa suggested primarily the possibility of an acutely inflamed appendix, possibly perforated. No cases of heat exhaustion associated with collapse had occurred up to that time; however, the conditions were then particularly trying, and the patient had been working in the engine room. His general appearance was consistent also with the effects of exposure to excessive heat. The diagnosis then rested between an acute condition of the abdomen and heat exhaustion.

The patient was put to bed and placed in Fowler's position, with a special watch for temperature and pulse recordings. Fluids were freely administered, and half a drachm of sodium chloride in ten ounces of water was given every hour. He responded to this treatment; a slight improvement could be noticed within two hours, and this was maintained. Within twelve hours his pulse rate had dropped considerably, and his pulse was strong, his respirations were normal, and his general appearance was much more comfortable. After twenty-four hours' treatment his condition was practically normal. He was allowed up the following day, and subsequently discharged to duty, the only treatment required being a simple one; he was back to full duty within a few days.

Two other cases of complete collapse occurred within a short time after the one just described; in one abdominal

symptoms were prominent as in the case just recorded, and in the other a straight-out collapse occurred. Subsequently 22 cases, embracing all types of effects of heat except sunstroke, occurred; seamen, cooks and telegraphists were affected as well as stokers. Those with the gastric type of lesion had epigastric discomfort, vomiting, headache, and the general feeling of being "off colour" (restlessness and irritability).

One of those affected by the gastro-intestinal type of lesion was a medical officer, who described the condition as one of profuse and continuous diarrhoea, with watery stools. The only treatment adopted in this case was the ingestion of three tablets (30 grains each) of sodium chloride twice a day for two days, and then a maintenance dose of one tablet twice a day. The patient described the relief as quite dramatic.

This resembled very closely the condition encountered frequently in the Mediterranean Sea, and especially in Egyptian ports.

One case of cramp was of a particularly severe nature. The patient was "doubled up", in obvious distress, presenting the typical picture of cold, clammy skin, profuse sweating, increased respirations, weakness and collapse. The administration of sodium chloride once more had dramatic results, and within two hours the patient was practically normal. This particular rating—the broad, powerful, boxer type—had ignored the warning about taking salt, it apparently being too "sissy" a process for the maintenance of his rude health. However, he was soon convinced, and became a great advocate of the measure.

Prophylactic Measures.

Such, then, was the state of affairs in this ship, and the question arose as to what measures could be taken to minimize the effect of exposure to high temperatures.

It is known that sodium chloride (common salt) is lost from the body by excessive sweat secretion, and that this is an important factor in the causation of ill effects from heat; moreover, in the treatment of these cases it is administered according to the nature and severity of the condition, by mouth, as a rectal injection, intravenously or subcutaneously.

The ship at the time was continuously at sea, and so a comparison with the work of others, and perhaps the benefit of their experience, was not available. A study of text-books brought forth nothing really emphatic or applicable to the problem of how to prevent over 800 men, serving in a warship in the tropics under war conditions, from suffering from the effects of heat.

Price, under the heading of "Prophylaxis", states that "salt (Sodium Chloride) should be taken freely with food to compensate for the loss of Sodium Chloride by excessive sweat production".¹¹

Osler, discussing heat cramps, states that "in prevention, the taking of Sodium Chloride and water freely should be helpful".¹²

However, to be of any use, this must be an organized prophylactic measure, and one rigidly adhered to. A decision was made then to institute the practice that every officer and man in the ship should take, as a precautionary measure, half a teaspoonful of salt in water twice a day. The means taken to put this measure into practice was simply education of the personnel as to its necessity, by promulgation in the daily orders, by placing notices in every mess in the ship, and by word of mouth. I believe that in one ship the experiment was tried of putting salt in the drinking water—a procedure which was bitterly resented. The educational method was much better especially when salt tablets were available.

Comment.

Opportunities were limited at the time for contrasting and discussing with medical officers of the other ships their experiences on this matter, and for learning whether prophylactic measures were being carried out regularly.

In one instance only was the procedure rigidly enforced; but in the majority of others the frank admission was made that strict adherence to a daily increased amount of salt intake was a completely unknown procedure.

There were quite a number of ships in which deaths took place from the effects of heat. In the early part of this year, a young stoker rating was drafted from this ship. He was examined at the time and pronounced entirely medically fit, but on the third day in the new ship he was affected by the heat and subsequently died. There were other reports of numerous and serious but not fatal cases, the numbers of men affected causing concern. At one shore station where conditions were particularly trying, the extra daily intake of salt was an accepted routine measure among a large number of men.

Apart from the more severe cases, in which the patient has to be placed on the sick list, it is reasonable to presume that minor discomforts and symptoms may follow the loss of sodium chloride—headache, pain in the limbs, abdominal discomfort, diarrhoea, giddiness, restlessness and irritability; such symptoms, if more pronounced, would produce any of the types of illness previously described.

I have many favourable reports that the individuals concerned have felt better in general when adhering strictly to the routine intake of salt, than when it was not the practice. I can confidently state that no cases of ill effects of heat occurred when the routine outlined was faithfully carried out.

Conclusion.

1. Salt deficiency due to loss of salt under conditions causing excessive sweating gives rise to sickness of varying intensity and in many cases has proved fatal.

2. Under conditions when this deficiency is likely to arise, salt loss must always be considered in diagnosis in any case associated with abdominal symptoms.

3. It was noticed that when salt was administered in these cases of illness, the response to treatment became obvious almost immediately.

4. The rigid routine procedure of taking half a teaspoonful of salt in water twice a day was a successful prophylactic measure.

5. I am of the opinion that this measure should be instituted for all ships serving in the tropics, for ships during their passage through tropical areas (especially troopships), and also for all personnel living and stationed in tropical areas ashore.

Acknowledgement.

This paper is published by permission of the Director of Naval Medical Services, Surgeon-Captain W. J. Carr, C.B.E., R.A.N.

References.

- (1) "A Text Book of the Practice of Medicine", by various authors, edited by Frederick W. Price, 1937, pages 370, 371, 372.
- (2) W. Osler: "Principles and Practice of Medicine". Twelfth Edition, page 363.

POTATO DIET IN PEPTIC ULCER.

By L. J. J. NYE, F.R.A.C.P.,
Brisbane.

DURING a visit to Irish hospitals some years ago, I was interested to learn that peptic ulcer manifested itself relatively rarely in that country. Nobody appeared to be able to offer a satisfactory explanation as to why this should be. I assumed that it was probably due to one of two factors or to a combination of both: firstly, the majority of the population lead a simple, happy-go-lucky existence, free from the nervous tension which is so much a part of life in most other countries; and secondly, their diet is largely of vegetable type with potatoes predominating.

Investigation shows that, with the exception of the relatively few who are allergic to it, potato is an ideal food for peptic ulcer patients, for the following reasons.

Potato possess excellent food qualities; its caloric value is 25 Calories per ounce (old, boiled potatoes), while that of milk is 19 Calories per ounce. It is rich in minerals and in vitamins A, B₁ and C. The vitamin C content, which is greater than that of milk, makes potato specially valuable in the treatment of ulcer, since it has been established experimentally that vitamin C exerts an important healing influence on wounds. Furthermore, it has an alkaline reaction, and therefore assists as a neutralizer of acid. When mashed with milk and butter potato forms a bland, palatable food, which to most patients is a welcome addition to the usual list of monotonous milk foods.

On account of its ideal food value and its neutralizing effects, I have for a number of years been using potato in cases of peptic ulcer and have had excellent results. Its advantages in the first stage diet list are obvious when a comparison is made with the old Slippery type of diet. In this stage I advise two or more potato feedings daily, depending on the choice of the patient. For the patient's permanent diet I advise that potatoes should, as much as possible, be substituted for bread, which has an acid ash (white bread contains four cubic centimetres of N/10 acid and wholemeal bread 17 cubic centimetres of N/10 acid per ounce).

An Illustrative Case.

The following history and skiagrams demonstrate the result of the use of a diet consisting almost wholly of potato diet on a patient suffering from deep gastric ulcer.

An engineer, aged thirty-nine years, complained that for years he had suffered from dyspepsia of non-syndrome type, but for the previous three weeks he had had pain in the epigastrium about two hours after taking food; the pain was relieved by the ingestion of an alkaline powder, but not by food. Occasionally he was awakened from sleep with acute pain necessitating his taking a dose of the powder; sometimes the pain caused him to vomit, and this gave him relief until after the next meal. He smoked about twenty cigarettes a day and was a total abstainer from alcohol.

A test meal examination revealed a mild degree of hyperacidity, the acidity being 42° fasting and rising to 50° one and three-quarter hours after the meal. X-ray examination revealed a deep gastric ulcer on the lesser curvature of the stomach.

The patient was an intelligent man, who after having heard a full explanation of the rationale of the treatment, agreed to submit to the experiment of living almost entirely on potatoes for several weeks. Treatment was begun on July 23, 1940. A two-hourly régime of potatoes supplemented with milk and milk foods was instituted, but the bulk of his diet was made up of potatoes mashed with milk. His intake of potatoes averaged three to three and a half pounds per day (eight or nine large potatoes). He was advised to rest at home for a week, and "Amphojel" was prescribed in doses of one drachm three times a day one hour before meals, at bedtime and during the night. In a few days he was relieved of all pain. He then returned to his work.

On August 9 a progress X-ray examination revealed a great improvement in the ulcer, and on September 26 the radiologist could find no evidence of its presence after careful screening. The patient felt extraordinarily well, and had gained fifteen pounds in weight during the five weeks of this strict treatment. He was then advised to take the routine full bland diet with frequent feedings, taking at least two good helpings of potatoes per day. He has reported recently for review, and states that he has had no return of his symptoms since the treatment was instituted two years ago, in spite of long hours of anxious work. He has had no chemotherapy, but has adhered strictly to the dietetic régime, which included an abundance of potatoes and pumpkin.

Discussion.

Many other patients who were intolerant of milk have been successfully treated with a diet consisting mainly of potatoes. Ulcer patients are frequently agreeably surprised when advised to eat potatoes, as they are under the impression that they are indigestible. Another popular fallacy is that the skin of the potato contains most of the vitamins; but recent investigation has shown that these increase in quantity towards the centre of the potato. It

TABLE I.

	Potatoes (Old, Boiled).	Potatoes (Old, Baked in Skins).
Calories per ounce	25	32
Grammes per ounce:		
Carbohydrate	5.6	7.1
Protein	0.4	0.7
Fat	Trace	Trace
Milligrammes per ounce:		
Sodium	1.0	2.2
Potassium	92.0	193.0
Calcium	1.2	2.6
Magnesium	4.3	8.3
Iron	0.14	0.25
Copper	0.03	0.05
Phosphorus	8.2	13.7
Sulphur	6.3	11.8
Chlorine	11.6	26.8

is important, however, to know that much more food value is retained in the potato when it is baked in the skin, as is shown by Table I.

Reviews.

A BOOK ON AFTER-TREATMENT.

"AFTER-TREATMENT", by H. J. B. Atkins, of Guy's Hospital, has been written as a guide for general practitioners and house surgeons on the care of patients after operation.¹

The author has allowed himself a wide latitude and has extended post-operative care to include such subjects as the writing of reports and the giving of evidence in court.

In the preface he states: "In nine cases out of ten one surgeon of experience will perform the operations as well as another and if our results are to improve it will come once more from a study of the processes of healing and repair. . . . The subsequent health, or even the chances of survival, may be prejudiced by the kind of after-treatment the patient is given." It is apparent that surgeons in England do not take as much personal care of the details of after-treatment as do their confrères in Australia, and the fact that this excellent little book has been written shows an increasing interest in the improvement of surgical results by meticulous care in after-treatment. The detailed description covers the whole field of general surgery and the surgical specialities with the exception of gynaecology.

In the section on burns the author stresses the importance of shock and advocates treatment by the administration of blood plasma; he recommends the estimation of the hemoglobin concentration as a guide to the quantity to be administered. He recognizes the tannic acid treatment for burns, including light tanning for fingers and hands. For third degree burns he favours saline baths, followed by the use of *tulle gras*. No mention is made of the method of treatment by triple dye.

In the ear, nose and throat section complete details of the treatment after mastoid operations are given, including a whole illustrated page on the application of the mastoid bandage.

In the after-treatment of tonsillectomy, having detailed the usual methods of controlling bleeding, the author writes: "In the last resort the patient is made to stand up by the side of the bed until he faints when the bleeding will almost certainly be automatically arrested." This treatment is, no doubt, very satisfactory, but appears to be rather heroic.

An excellent section is devoted to the treatment of empyema, including full details on when to use drainage and how long the tube is to be left in place.

¹"After-Treatment: A Guide to General Practitioners, House-Officers, Ward-Sisters and Dressers in the Care of Patients after Operation", by H. J. B. Atkins, D.M., M.Ch. (Oxon), F.R.C.S. (England); 1942. Oxford: Blackwell Scientific Publications, Limited. Medium 8vo, pp. 243, with 47 illustrations. Price: 15s. net.

Three chapters are devoted to abdominal section. The author discusses in detail the treatment of paralytic ileus and provides a helpful review of the two schools of thought on this subject. Details are given of his own method of treatment which he admits is a compromise between stimulation and sedation, but, like many compromises, it works. This section might be read with advantage by any medical man.

Very complete details are given regarding the feeding of patients after operations for perforated peptic ulcer, and also for other stomach operations; there is a section on what the patient should eat after six months of complete freedom from symptoms.

The section on amputations gives details of the position and treatment of the stump, the fitting of artificial limbs, reeducation and such helpful items as how to go downstairs and how to drive a motor car with the aid of an artificial limb.

The section on fractures is particularly good and such items as X-ray control, the changing of plaster splints and the observation of circulatory disturbances are fully treated. The important principle that all joints not immobilized must be moved actively from the start is stressed and discussed in detail.

The book is written in an interesting and attractive manner and the phraseology and humanity of the writer make it easy and entertaining reading. The illustrations are not large in number but adequate, though some of the photographs lack sufficient detail. Finally, we must comment with admiration on the fact that a wartime London is still able to produce books on heavy art paper and to produce them so well.

DEVELOPMENT OF THE CHILD.

In "The Natural Development of the Child", by Agatha H. Bowley, a store of concentrated common sense has been packed into the small space of 163 pages.¹

The book gives a brief account of the normal growth and development of children from babyhood to adolescence, indicating when and how difficulties occur, and how they can best be handled. Although written primarily for the guidance of student teachers, the book can well be recommended to any intelligent parents who are eager to gain light on the personality development of their children; while those who wish to delve further will be interested in the suggestions for further reading given at the end of each chapter.

Dr. Bowley is no mere theorist—she has had considerable experience in both general and nursery school teaching, is a lecturer in a teachers' training college and has organized and directed the very successful child guidance clinic at Dundee. She possesses a genuine understanding of the very real problems of the young.

The first chapter describes the milestones of development, and the general characteristics of intellectual, social and emotional growth during infancy. Or, to put it in more specific terms, it discusses such things as feeding, toilet training, and thumb sucking—problems which seem to beset most parents to some degree.

The pre-school years are dealt with more fully than any other period; this is necessarily so, as it seems trite now to observe that the fundamentals of any child's character pattern are well laid down before he ever gets to school.

The difficulties which are particularly characteristic of the middle years of childhood are classified as backwardness and educational difficulties, delinquency and antisocial behaviour, and anxiety conditions and habit disorders. The case studies used as illustrations and the remedial measures suggested in this section again bear witness to the sound practical experience of the writer.

A concluding section on children and the war gives wise and timely comments on the circumstances in which children now have to be brought up.

Whilst more detail would be welcome from such a sound writer, the brevity of the volume should make it possible for busy doctors to read it with advantage.

¹"The Natural Development of the Child (A Guide for Parents, Teachers, Students, and Others)", by Agatha H. Bowley, Ph.D., with a foreword by D. R. MacCallman, M.D.; 1942. Edinburgh: E. and S. Livingstone. Crown 8vo, pp. 190, with 84 photographic illustrations. Price: 8s. 6d. net.

The Medical Journal of Australia

SATURDAY, JANUARY 2, 1943.

All articles submitted for publication in this journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

References to articles and books should be carefully checked. In a reference the following information should be given without abbreviation: Initials of author, surname of author, full title of article, name of journal, volume, full date (month, day and year), number of the first page of the article. If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

Authors who are not accustomed to preparing drawings or photographic prints for reproduction are invited to seek the advice of the Editor.

DISCUSSIONS ON A GENERAL MEDICAL SERVICE FOR AUSTRALIA.

SINCE the last meeting of the Federal Council of the British Medical Association in Australia which was reported in this journal in the issue of November 14, 1942, important events happened in the medico-political sphere in this country. Readers will remember that at its last meeting the Federal Council gave a good deal of time to the discussion of a general medical service for the people of Australia. At its previous meeting a year before it had adopted a scheme for a service based on a report drawn up by a subcommittee of two of its members. This service was to apply to persons whose incomes fell below a certain limit and it was to be subject to a *per capita* system of payment. In the course of the last meeting the Council at the instance of the President discussed in detail two schemes for a salaried service—one drawn up by the National Health and Medical Research Council and the other drawn up by a subcommittee of the Council of the Victorian Branch. The Federal Council discussed these schemes so that its members would gain an understanding of them, in other words, so that they would be familiar with every aspect of the subject. Having considered these schemes for a salaried service, the Council resolved that the Branches should be asked to consider them and to send their comments and criticisms for consideration at its next meeting. This, we pointed out at the time, was logical and gave the Branches an opportunity to try to achieve unanimity. Since then, as already stated, important developments have taken place and it is right that members of the Branches should be informed of them.

Before any recent developments are mentioned it should be recalled that the Commonwealth Minister for Health, the Honourable E. J. Holloway, in response to representations from the Federal Council, promised that no general health service would be introduced before the end of the war. He addressed the following letter to the President of the Federal Council:

COMMONWEALTH OF AUSTRALIA.

Minister for Health,

Commonwealth Offices,

Melbourne, C.2,

19th January, 1942.

Dear Sir Henry,

Your letter of the 15th January is to hand in which you discuss the plan for a National Salaried Whole-time Medical Service which has been submitted to me by the National Health and Medical Research Council, and the desirability of deferring its introduction until after the war, and also that the views of your Association should be canvassed before any final decisions are arrived at.

In reply I wish now to reiterate my promise that you will be consulted; also you can be assured that the scheme will not be introduced until after the war.

Best wishes,

Yours sincerely,

(Signed) E. J. HOLLOWAY,

Minister for Health.

Sir Henry Newland, M.S., F.R.C.S. (Eng.), F.R.A.C.S.,
163 North Terrace,
Adelaide, S.A.

In view of this promise it was with some amazement that the President of the Federal Council on November 18, 1942, received a telegram from the Chairman of the National Health and Medical Research Council, Dr. J. H. L. Cumpston, stating that at the request of the Parliamentary Joint Committee on Social Security the National Health and Medical Research Council would at a meeting in the following week consider whether the whole or any portion of the Council's outline of a salaried medical service should be introduced during the war. In view of the absence from Australia of Dr. J. Newman Morris, the Federal Council's representative on the National Health and Medical Research Council, Dr. Cumpston invited the President, Sir Henry Newland, to attend or to nominate a substitute. Sir Henry Newland replied by telegram thanking Dr. Cumpston for this courteous invitation, but added that in view of the Minister for Health's repeated assurance that no national health service would be introduced during the war he must decline to attend. His telegram concluded with the words: "On behalf of medical profession in Australia I protest against introduction of salaried service without fullest consultation with profession." In a letter to Dr. Cumpston, under the date November 20, 1942, Sir Henry Newland wrote: "As regards the purport of your telegram, it is my duty as President of the Federal Council of the British Medical Association, to point out to you that the Minister of Health in a letter to me, reiterated his undertaking that a salaried medical service would not be introduced during the war. This assurance was sought from the Minister, mainly because the absence of medical practitioners overseas debarred them, not only from expressing their views on such a service, but also from applying for posts in it. . . . I can imagine nothing more likely to excite the most bitter resentment of medical practitioners abroad and at home than the introduction, at the present time, of a national salaried medical service." The National Health and Medical Research Council must have come to much the same sort of conclusion, for Dr. Cumpston announced in evidence before the Parliamentary Joint Committee on Social Security that the National Health and Medical Research Council had adopted a resolution reaffirming the principles contained in its outline for a possible scheme for a salaried service and stating its belief that the proper course was to wait the results of

the constitutional discussions before elaborating any proposals for the change of medical practice in Australia.

The events so far enumerated have no immediate significance, but two recent happenings must be mentioned which are likely to have far-reaching results. In the first place the recent convention at Canberra has agreed that national health is one of the matters which will be the joint responsibility of the Commonwealth and the States. In regard to this decision it has been stated that the Commonwealth will call the tune and the States will dance to it. Secondly the announcement in Great Britain of the Beveridge plan has created a profound impression, not only in the Old Country but also in Australia. Commonwealth ministers have lost no time in declaring that the Commonwealth Government had intentions at least equal to, if not more complete than, those of the Beveridge plan. This then is the stage which the present happenings have reached. The Parliamentary Joint Committee on Social Security is taking evidence from practitioners in different States and the inquiries made by its members have been far reaching. The committee has more than once insisted to witnesses that it has no preconceived plan and that it intends to sift available evidence in a search for the most suitable scheme of medical service for Australia. The method of procedure adopted with the witnesses would warrant the acceptance of this statement. To one aspect of the procedure some exception may be taken, and that is the fact that witnesses appear to have been selected and that no general invitation was given for volunteers to give evidence. The opinions expressed by witnesses are so divergent, however, that in the long run the method of selection may not matter. What really matters is that views of all kinds shall be brought to the notice of the committee.

From the foregoing it will be clear that there is greater need than ever for discussion among members of the Branches so that they may determine what their attitude to future proposals for change is to be. In all discussions of this kind it would be well to bear in mind the determinations of the Canberra Convention, the implications of the Beveridge plan and its possible reflections in this country. These factors appear likely to have some bearing on such schemes as the Federal Council *per capita* payment and income-limit scheme; to what extent this is so must be determined. It is most unfortunate that the *British Medical Journal* of June 20, 1942, containing the interim report of the British Medical Association Medical Planning Commission has not reached Australia; this document might be helpful to the Australian Branches at the present time. What is really important is that everyone—parliamentarians, doctors and the general public—should realize that a medical millennium will come by evolution; to attempt to produce satisfactory results by revolutionary methods will be to court disaster. The doctors must sense the evolution and endeavour to lead it along lines that will benefit the community and increase their efficiency as doctors.

Current Comment.

SPRUE.

SPRUE is no longer "one of those mystical diseases that you get out in the East"; much has been learnt of it in

recent years. The development of liver therapy has changed it from a chronic and often deadly disease to one that is readily curable. Furthermore, and what is more interesting, it is now known to be identical with the idiopathic steatorrhœa (sometimes called "non-tropical sprue") of adults and celiac disease of children. The syndrome of steatorrhœa, macrocytic anemia, hypocalcemia, emaciation and intestinal flatus, then, may appear in any country; it is known as "sprue" only when it appears in a tropical setting. It is commoner in the tropics because certain antecedent conditions, such as intestinal infection and inadequate diet, are commoner in such places. Knowledge of the syndrome is of importance to all practitioners of medicine. A valuable paper dealing with the pathogenesis of sprue has recently appeared under the name of Sir Arthur Hurst.¹ Hurst draws attention in the first place to the work of Verzár and McDougall on the subject of absorption from the small intestine, and he acknowledges the help that their monograph has been to him in the compilation of his paper. He points out that the mucous membrane of the small intestine is "specially adapted for the absorption of water, water-soluble substances, fat and gas by the great extent of its surface resulting from" the *valvule conniventes*, into which it is folded. These folds, which are highest, widest and nearest to each other in the duodenum and upper part of the jejunum, vary from one to two millimetres in width and are separated from each other by spaces of one to three millimetres. They produce a characteristic "feathery or herring-bone appearance" on X-ray examination after a barium meal. The pattern alters constantly because of the activity of the *muscularis mucosæ*. The surface of the mucous membrane is further increased by the presence of villi, which are from 0.2 to 1.0 millimetre in height and number from 20 to 40 per square millimetre. Fibres of the *muscularis mucosæ* pass into the villi to be attached to the outer surface of the central lacteal or to the basement membrane of the epithelium.

The intestine cannot absorb neutral fats or fatty acids, both of which are insoluble in water. The conversion of fatty acids to soluble alkaline soaps is impossible in the slightly acid medium of the intestinal contents. But bile salts are able to combine with them, forming water-soluble complexes, which are absorbed by the epithelial cells of the villi. Once they enter the epithelial cells they break down into fatty acid and bile acids. The fatty acid is built up to neutral fat by the action of glycerol. The bile acid returns to the intestine to assist in the conversion of more fatty acid to a substance fit for absorption. It is of interest to note that the synthesis of fat in the epithelial cells is inhibited by adrenalectomy, and Verzár concluded that sprue, idiopathic steatorrhœa and celiac disease were manifestations of adrenal insufficiency; but, as Hurst points out, "there is no clinical or pathological support for this view, as the suprarenal glands are normal in these diseases and no other symptoms of Addison's disease are present, and there is no excess of fatty acid in the stools in Addison's disease". The villi shorten quickly by action of the *muscularis mucosæ* and lengthen more slowly. "As they do not become thicker when they contract, it is clear that the contents of the central lacteal must be pressed out at each contraction." The contractions of the villi are independent of Auerbach's plexus, as acetylcholine has no effect on them. Verzár has shown that they are caused by stimulation of Meissner's plexus. The stimulus may be provided by crude yeast, histamine, physostigmine and a hormone known as villikinine, but not by pure vitamin B₁ or vitamin B₂. The one constant abnormality in the stools in sprue, idiopathic steatorrhœa and celiac disease is the presence of sheaves of needle-shaped crystals of fatty acids and soaps; there is no excess of neutral fat. There is no evidence of pancreatic insufficiency. Bennett and Hardwick have given the name of "chronic jejuno-ileal insufficiency" to the various types of the sprue syndrome. But Hurst points out that this name "does not sufficiently emphasize the specific nature of the insufficiency—the inability of the small intestines to absorb split fat".

¹ *Guy's Hospital Reports*, Volume XCI, Number 1, 1942.

Furthermore, intestinal carbohydrate dyspepsia is also a manifestation of jejuno-ileal insufficiency, and it is absent from the sprue syndrome. Hurst regards the term "sprue syndrome" as the best title. In discussing the symptoms of sprue Hurst writes: "Hypocalcæmia, tetany and decalcification and deformity of bones, hypochromic and hyperchromic anæmia, stomatitis and glossitis, achlorhydria, distension of small and large intestine with gas, and vitamin deficiencies may all be present, but many cases occur without one or more often several of these conditions." The hypocalcæmia is due to the combination of calcium with fatty acid in the intestine and its subsequent excretion. Deficiency in fat-soluble vitamins is not a constant feature; for the absorption of fat is not completely lost. Thaysen has shown that the blood fat content invariably rises after a meal. A feature of great interest is the low glucose tolerance curve in sprue. This has been attributed to delayed absorption of glucose or to some disturbance in sugar metabolism. But Hainsworth has shown that a similar curve results when the glucose tolerance test is applied to healthy persons who are fed on a purely carbohydrate diet and that a curve indistinguishable from that of diabetes results when the test is applied to a healthy person who has been given a diet of fat.

In the radiological examination of patients with sprue it is noted that the pattern made by the *valvula conniventes* is coarser or is completely lost. The barium tends to separate into a number of masses. In severe cases its shadow looks like the silhouette of wax that has been poured into a tube and allowed to set. For this reason Kantor called the characteristic X-ray appearances the "moulage sign". These appearances vanish, and normal appearances return, on recovery from the disease. It has been suggested that the radiological signs result from thickening of the mucosa as a result of inflammation. But Hurst points out that they do not occur in enteritis.

Most of the post-mortem appearances described in sprue are really changes that have occurred *post mortem*. They are absent when formalin has been injected into the abdominal cavity immediately after death. Atrophic changes are no more than would be caused by the general malnutrition of the patient. Round-celled infiltration and even ulceration of the mucosa are occasionally found. It is suggested that these inflammatory changes are caused by the irritation of free fatty acids. Hurst has found by sigmoidoscopy in normal persons that a soap enema "causes congestion of the mucous membrane of the colon with excessive secretion of mucus containing many desquamated epithelial cells and occasionally leucocytes and even red corpuscles". Degenerative changes in the myenteric and submucosal plexuses have been found. Several investigators have noted absence of the jejunal rugæ or "disappearance of the *valvula conniventes* in the areas involved by the moulage sign". Hurst remarks that the "absence of a demonstrable parasitic agent such as a virus, bacterium or fungus, the apyrexial course of the disease, and the non-inflammatory nature of the tissue changes are . . . against an infective origin" of sprue. But paralysis of the *muscularis mucosæ* "would result in flattening or disappearance of the *valvula conniventes* and the characteristic changes in the radiographic appearance of the duodenum and jejunum".

Paralysis of the extension of the *muscularis mucosæ* into the villi would result in cessation of the pumping action of the villi. Consequently fat would cease to be absorbed, but the activity of the pancreas would be unaffected so that the digestion of fat would take place as usual. The stools would consequently contain a great excess of split fat but no excess of neutral fat—i.e. they would have the characteristic features of the stools of sprue and celiac disease. Such paralysis would not alter the microscopical appearances of the mucous membrane, and restoration of normal fat absorption with reappearance of the *valvula conniventes* would follow recovery of the functional activity of the *muscularis mucosæ*.

The cause of the failure of the *muscularis mucosæ* is unknown. Manson-Bahr has found that the administration of nicotinic acid has a "more rapidly favourable action on sprue than any other treatment". Possibly a deficiency of

this vitamin plays a part in the causation of the disease.

Hurst points out finally that cases presenting symptoms identical with those of sprue are caused by obstruction to the lymphatic flow by disease of the mesenteric glands. Such cases differ from sprue only in the fact that the obstruction to fat absorption occurs in the lymphatics rather than in the villi. According to Davenport Jones, obstruction of the lacteals by tuberculous glands (less frequently by lymphadenoma, lymphosarcoma and carcinoma) is the cause of non-tropical sprue in most cases. Witts found that in one such case the normal feathery pattern of the small intestine as revealed by X rays had not been altered. Hurst declares therefore that the radiological appearances in sprue cannot be due to the presence of excessive amounts of fat in the intestine, but must be due to the disappearance of the *valvula conniventes*.

Hurst is unable to ascribe a cause to his hypothetical paralysis of the *muscularis mucosæ* and hence a cause to sprue. An attempt to fill this gap is made by Z. A. Leitner.¹ Leitner states that the primary cause of sprue is a breakdown of normal absorption in the upper part of the small intestine. He then proceeds to give a series of secondary causes. Although it has been shown that in some cases of sprue the gastric secretion is not altered, Leitner states that disturbances of the gastric secretion are too frequent to be disregarded. He therefore gives as the first of the secondary causes "deficiency in gastric secretion and hydrochloric acid necessary for coordination of intestinal functions". The next is achlorhydria, which affects the motility of the villi and "decreases the vitamin B content of food". Stagnation of intestinal contents occurs, and bacteria flourish. Normally hydrochloric acid prevents the excessive multiplication of bacteria; but in achlorhydria, bacteria (especially *Bacterium coli*) migrate and multiply and cause putrefaction of the contents of the small intestine. It has been shown that certain strains of *Bacterium coli* are able to deaminate amino-acids, especially tyrosine; "the resulting tyramine, when injected, produces macrocytic anæmia and liver damage". Leitner thinks that this is what happens in sprue, the metabolism of iron failing, and hæmoglobin metabolism being "perverted to increasing amounts of porphyrin". In sprue also, according to Leitner, the excretion of bilirubin is decreased. As a result of liver damage the production of bile salts is diminished, and so hydrotropy and fat absorption are reduced. The unresolved fatty acids in the small intestine form insoluble calcium salts; "this affects the bones and then the whole electrolyte equilibrium". The development of this stage may go on for years. The excessive production of porphyrin causes paralysis of Meissner's plexus; the motility of the villi is diminished; the cytochrome enzyme system essential for hydrotropy, osmosis *et cetera* breaks down; steatorrhœa occurs. Finally "an acute vitamin B deficiency is . . . produced".

It will be seen that Leitner's thesis is dependent mainly on a belief in the great importance of iron.

These two papers are among the most valuable contributions on the subject of sprue to appear within recent years. They do not provide a solution to the sprue problem; but they do suggest logical means of tackling the problem and they provide us with the hope that the solution is not far distant.

INDEX TO "THE MEDICAL JOURNAL OF AUSTRALIA".

OWING to restrictions in the use of paper, the half-yearly index to THE MEDICAL JOURNAL OF AUSTRALIA which in normal times would have been published in the issue of December 26, 1942, will be issued again separately in a few weeks' time and sent to those who wish to have a copy. It will not be necessary for those who received a copy of the last half-year's index to ask for another on this occasion. Others should make written application to the manager at The Printing House, Seamer Street, Glebe, New South Wales.

¹ Tropical Diseases Bulletin, August, 1942.

Abstracts from Medical Literature.

THERAPEUTICS.

The Toxic Effects of Sulphonamides.

S. C. LITTLE (*The Journal of the American Medical Association*, June 6, 1942) discusses the nervous and mental effects of the sulphonamides. These drugs are excreted mainly by the kidneys. In the presence of impaired renal function they should be given cautiously. Increased fluid intake expedites their elimination. The nausea, vomiting and diarrhoea due to sulphonamides result from their effect on the nervous system; headache, tinnitus and giddiness have the same cause. Azosulphamide ("Neo-Prontosil") was little used. It was supplanted by sulphanilamide. Only one case of its toxic effects is recorded. Sulphanilamide may cause depression or euphoria, dysmorphism, aphasia, agraplia and psychoses of ordinary types, coming on after one dose or more, usually after the taking of several grammes of the drug. Neuritis, with or without pain, myelitis, diplopia, myopia and optic neuritis have been recorded. All toxic effects become less on withdrawal. Sulphapyridine may cause confusion, restlessness and irritability, and persistence of meningeal symptoms after three days' treatment. Neuritis with paralysis also occurs. Intrathecal injection of sodium sulphapyridine has been known to cause necrosis of the spinal cord. Sulphanilysulphanilamide (di-sulphanilamide, "Di-sulon") was widely used in Europe, but its use was discontinued owing to the number of toxic effects on the nervous system, particularly peripheral neuritis. Di-methyl di-sulphanilamide had similar toxic effects. Sulphathiazole is more toxic to the nervous system than sulphapyridine; it may cause mild or severe peripheral neuritis, psychoses and other toxic nervous effects. Sulphamethylthiazole was slightly more toxic to the nervous system than sulphathiazole. Sulphaguanidine has not so far been recorded as a cause of toxic effects on the nervous system, possibly because so little enters the blood. Sulphadiazine caused nausea and vomiting in 9.2% and headache and giddiness in only 0.5% of 400 patients treated. Serious nervous or mental effects were not observed in this series, though one case of peripheral neuritis has been recorded elsewhere. It has been said that intermittent dosage with sulphonamides is more likely to cause nervous symptoms and that this may be due to sensitization.

Sulphonamides.

A. M. FISHER (*Journal of the Mount Sinai Hospital*, January-February, 1942) discusses the use of sulphonamides in renal insufficiency. Renal complications such as renal colic, hematuria, anuria or obstructive oliguria may occur during sulphonamide therapy, owing to precipitation of the relatively insoluble acetylated sulphonamides. The author reports the case of a girl, aged thirteen years, who suffered from chronic pyelonephritis associated with anaemia. The patient developed pneumonia. One gramme of sulphathiazole was given four times in thirty-six hours. The blood concentration was 11 milli-

grammes per centum three days later, and was still 6 milligrammes per centum nine days after administration of the drug was suspended. The temperature came to normal on the second day of the illness and there were no ill effects from the drug. This case illustrates the fact that impairment of renal function results in a higher blood level from a given dose and a more prolonged elevation of the sulphonamide in the blood stream.

Sulphamethazine.

D. W. MACARTNEY and others (*The Lancet*, May 30, 1942) have made a clinical trial of sulphamethazine, a new sulphonamide related to sulphadiazine, in pneumonia and in a few cases of meningococcal meningitis and gonorrhoea. They report that the drug is as efficient as sulphapyridine in the treatment of pneumonia and highly efficient in the treatment of the other two diseases. Moreover, on account of the high solubility, it is unlikely to cause renal damage and cyanosis does not follow its use. The incidence of nausea and vomiting is much less than with sulphapyridine.

Agranulocytosis.

R. OTTENBERG (*Journal of the Mount Sinai Hospital*, January-February, 1942) describes a new treatment for leucopenic states. Nucleotide therapy has not been generally accepted; transfusion has a limited effect. The injection of foreign protein into the donor, however, produces a temporary leucocytosis of 15,000 to 30,000 per cubic millimetre. Injection of foreign protein into the patient suffering from granulopenia generally fails to produce a leucocytosis because of the damaged bone marrow. In the case recorded the author injected 15 million killed typhoid bacilli intravenously into the donor of the blood the day before he utilized the blood for transfusions. On the day of the transfusion the donor's blood contained 28,500 leucocytes per cubic millimetre. The patient, who had a sore throat, was given 15 grains of sulphonamide in twelve hours. She improved, but a week later developed high fever, otitis media, pharyngitis and impetigo. A blood count revealed 9,100 leucocytes per cubic millimetre with only 0.5% polymorphonuclear cells. A transfusion of 150 cubic centimetres from the donor mentioned above led to immediate remarkable improvement. The patient, who had been very seriously ill, felt better at once; the temperature fell from 105° to 101° F. and then to normal in a few hours. The blood count a day later revealed 34% granulocytes among 10,000 leucocytes. Complete recovery occurred.

The Nephrotic Crisis.

K. EMERSON and D. D. VAN SLYKE (*Journal of the Mount Sinai Hospital*, January-February, 1942) describe the symptoms of the nephrotic crisis and its treatment by intravenous injection of amino acids. The nephrotic crisis is a recurrent febrile attack with symptoms of peritonitis in a patient suffering from nephrosis. The onset is sudden with a rise in temperature up to 106° F. in three or four hours, chills, generalized abdominal pain and rigidity, nausea, vomiting and prostration. A leucocytosis occurs and a pneumococcus, streptococcus or other organism is often found in cultures of peritoneal fluid. Bacteremia and death or recovery may

occur. Farr showed that a loss of urinary non-protein nitrogen preceded the crisis. The normal α -amino acid nitrogen of the blood plasma (3.5 to 5.0 milligrammes per 100 cubic centimetres) was consistently decreased in the nephrotic syndrome to 2.5 to 3.5 milligrammes per 100 cubic centimetres. During the acute nephrotic crisis the figure dropped to below 2.5 milligrammes. This was the critical level. Recovery was associated with an abrupt rise in the amino acid in the plasma. During the crisis gastro-intestinal symptoms are so acute that feeding is impossible. Consequently the amino acids have been given intravenously in the form of casein hydrolysate. It is not claimed that this treatment has prevented or shortened the nephrotic crisis, but the fact is that since the introduction of amino acid therapy the mortality from crises has diminished remarkably. MacLeod and Farr observed that nephrotic children carried in their throats for a long time the organisms which subsequently invaded the blood stream in a nephrotic crisis.

Gout.

C. MCOWEN (*Journal of the Mount Sinai Hospital*, January-February, 1942) describes the use of diets with high fat and high purine contents in the diagnosis of gout. Gouty patients were given a diet with a high fat content (260 grammes), with a low protein content (45 grammes), and with carbohydrate (50 grammes). The protein was mainly derived from milk, eggs and cheese. On this diet the blood uric acid content rose slightly higher than it had been before, and patients suffered pains in the great toe, feet and other joints, typical of gout. Other patients were given diets with a high carbohydrate content (300 grammes), with moderate protein (70 grammes) and fat (85 grammes); symptoms became less and the blood uric acid content less. The blood uric acid content was between five and nine milligrammes per centum during attacks of gout; it rose to its maximum, eleven milligrammes in one case, after ingestion of a high purine diet. The diet with a high purine content contained 119 grammes of carbohydrate, 143 grammes of protein and 87 grammes of fat. Meat was given at every meal, and thymus, liver or sweetbreads once a day. On this diet gouty symptoms occurred more readily and the blood uric acid was higher than on a diet with a high fat or high carbohydrate content. There appeared to be no doubt in these experiments that a diet with a high carbohydrate content with 70 to 80 grammes each of fat and protein was by far the most satisfactory from both the clinical and biochemical aspects of gout.

Results of Treatment by Intramuscular Injection of Histaminase.

MAURICE VAISBERG (*The Journal of Laboratory and Clinical Medicine*, February, 1942) considers that much more clinical work must be done with a potent, highly purified histaminase before the validity of any claims as to its efficiency as histaminase alone can be firmly established. Only then will it be possible to interpret correctly the separate effects of the histaminase and the other protein and non-protein constituents of the solution. In the author's investigations histaminase

solution
labora-
The s-
phate
powde-
muscu-
ranged
centim-
at one
Early
usually
if the
Ninete
histam-
asthma
three
two
patient
two h-
dition
might
hospit-
from
itching
three
motor
relief
urtica-
one p-
migrat-
relief
sickne-

NEU

The

JOAC
Nervou
1942)
convu-
therap-
vulso-
ness
(b) t-
death
destru-
forma-
of the
psych-
patient
author
peutic
by ve-
that
obtain-
fore c-
functi-
amoun-
death
unloa-
mann

Hyp

H.
Quart
gener-
functi-
the p-
intra-
used
phren-
simila
inject-
made
was
maxim-
of the
tions
obtain
differ-
differ-
mecha-
is par

solutions were prepared in the laboratory from fresh kidney tissue. The solution used was the first phosphate buffer extraction of hog kidney powder, and was injected intramuscularly in all cases. Its potency ranged from 5 to 25 units per cubic centimetre. The usual maximum given at one time was ten cubic centimetres. Early in each case injections were usually given twice a week, and later, if the condition improved, once a week. Nineteen patients were treated with histaminase. Of the six treated for asthma, one was considerably improved, three were temporarily relieved, and two were not improved. Of four patients suffering from neurodermatitis, two had variable relief, and the condition of two who were in hospital might have improved just from the hospital stay. One patient suffering from pruritus had dramatic relief from itching in several hours. None of the three patients suffering from vasomotor rhinitis experienced the slightest relief. Two patients with chronic urticaria had no relief whatsoever, and one patient with dermatographia and migraine had no relief. Permanent relief was given in one case of serum sickness in three hours.

NEUROLOGY AND PSYCHIATRY.

The "Discharging Function" of the Convulsive Seizure.

JOACHIM FLESCHER (*The Journal of Nervous and Mental Disease*, September, 1942) examines the effect of artificial convulsions from the Freudian angle. Other writers, he contends, explain the therapeutic process of induced convulsions by: (a) the sense of helplessness increases the need for support; (b) the situation, which approaches death by its violence, represses or destroys the younger pathological formations by increasing the activity of the primitive life instincts; (c) the psychic factor fear of death forces the patient out of his autistic attitude. This author stresses the fact that the therapeutic convulsive seizure is accompanied by vehement motor manifestations and that the best curative results are obtained with melancholics. He therefore concludes that by the discharging functions of the artificial fit huge amounts of energy inherent in the death and destructive drives are unloaded in an individual and harmless manner.

Hyposensitivity to Foreign Protein in Schizophrenic Patients.

H. B. MOLHOLM (*The Psychiatric Quarterly*, July, 1942), admitting a generalized hypoactivity of various functions in schizophrenia, investigated the position of immunity by repeated intracutaneous injections of a protein used as an indicator. Twelve schizophrenic patients were compared with a similar number of normal males: injections of guinea-pig serum were made every week for thirteen weeks. It was found that the mean areas of maximum erythematous skin reaction of the patients to the successive injections were significantly less than those obtained with normal subjects. The difference is believed to lie in the difference in their local vascular mechanisms; in the schizophrenic this is part of a general hypoactivity. The

author suggests that a study of immunological reactions may be a profitable approach to the biological antagonism between certain pathological conditions and certain forms of constitution.

The Significance of Abnormal Electro-Encephalograms.

DENIS WILLIAMS (*Journal of Neurology and Psychiatry*, July and October, 1941), in order to determine the relative significance of an abnormal electro-encephalogram, surveyed the clinical and electro-encephalographic examinations of 900 subjects. He used the standard three-channel ink writing electro-encephalograph with condenser coupled amplifiers. The abnormality rate, he found, varied from 5% in the highly selected group to 60% in the epileptic. Of the subjects with an abnormal response to overbreathing, 75% showed abnormality in the resting electro-encephalogram. The author concludes that an abnormal electro-encephalogram in an otherwise normal subject is strong evidence of an inborn constitutional abnormality involving the central nervous system, which may become manifest in some behaviour abnormality in the offspring. Of epileptics 40% have a normal electro-encephalogram between their fits.

The Psychopathology of Some Confusional States.

WENDELL MUNCIE (*The Journal of Nervous and Mental Disease*, August, 1942) asserts that the average human being basks in the sunlight of certainties; and he then proceeds to describe cases of pathological uncertainty of grasp referred to as confusion. Reference is made to cases of toxic confusion, Korsakoff's psychosis and certain types of the manic-depressive reaction. The writer believes that human development includes the plotting of points of orientation, and that there is constant reference to them in the growth of the spontaneously acting person in relation to the environment. Disruption of any element in the system of arranged orientation points may serve to disturb the whole system. For satisfactory functioning of the personality "the centre of gravity" must reside within the person. If it shifts outside the person, confusion may result. Treatment by insulin or "Cardiazol" may furnish a new rallying point for therapeutic rapport which may lead to a unified activity programme. Search for the essential aetiology will be best aided by appraisal of the relative degree of disturbance in the personal and impersonal orientation.

The Use of Synthetic Vitamin E in Various Neuro-Muscular Disturbances.

BECAUSE of the divergence of opinion relating to the use of vitamin E in certain neuromuscular conditions, Gabriel A. Schwartz, George D. Gammon and Richard L. Masland (*The Journal of Nervous and Mental Disease*, September, 1942) have studied its effects in eighteen patients: eight with progressive pseudohypertrophic muscular dystrophy, four with the adult form of muscular dystrophy, one with progressive spinal muscular atrophy, two with amyotrophic lateral sclerosis, one with lateral sclerosis, one with postero-lateral sclerosis and one doubtfully classified as *amyotonia congenita*.

All were given a-tocopherol by mouth, up to 50 milligrammes per day for four months or longer. Eleven of the patients also took whole wheat germ cereal. The results were disappointing. There were no objective evidences of improvement in any of these cases, although five patients with dystrophy reported some slight subjective improvements, and three continued to progress while under treatment.

Intravenous Use of Insulin in the Hypoglycæmic Shock Treatment of Schizophrenia.

WITH a view to modifying the standard insulin treatment to meet wartime conditions of economy, R. A. Sandison and James S. McGregor (*The Journal of Mental Science*, July, 1942) began to experiment with the intravenous administration of insulin and glucose, giving the patient a drink of potato soup in place of the customary glucose on waking. In this way they effected considerable saving of material. These authors state that the intravenous use of insulin ensures rapid recovery from coma and obviates the dangers of delayed recovery and late shock. They claim that the carbohydrate intake can be lowered. Comparative blood sugar investigations show that the hypoglycæmia occurs more rapidly and is more profound after intravenous administration of insulin: recovery after termination is more rapid. The mode of action of insulin is discussed in relation to autonomic functions and the view is expressed that insulin achieves remission by stimulating the automatic regulating centres which in schizophrenic patients are depressed. Investigations on the gastric juice show that insulin given intravenously is a more powerful stimulant than insulin given intramuscularly. The authors, investigating the behaviour of the sugar tolerance, express the view that this is largely dependent on the duration of the disease. In long-standing cases there is little change in sugar tolerance as the result of insulin treatment, and in such cases the autonomic centres receive little stimulation even by prolonged insulin treatment. They found little difference between the intramuscular and intravenous methods in regard to the sugar content of the cerebrospinal fluid; and they believe that the fall of sugar content is coincident with the onset of coma and not the cause of it. They conclude a very thorough survey with the belief that intravenous use of insulin is the method of choice.

Treatment of Epileptics with Sodium Diphenyl Hydantoinate and Phenobarbital Combined.

H. HOUSTON MERRITT AND CHARLES BRENNER (*The Journal of Nervous and Mental Disease*, September, 1942) compare the efficacy of the treatment of 100 epileptic patients by sodium diphenyl hydantoinate alone and with the addition of phenobarbital. The condition of thirteen patients was much improved by the combination, that of 21 patients was moderately improved, while 66 showed no significant change. The authors believe that epileptic patients whose seizures are unsatisfactorily controlled by sodium diphenyl hydantoinate alone, should be tried with this drug in combination with phenobarbital. They believe that to obtain satisfactory results full doses of both drugs must be used.

British Medical Association News.

ANNUAL MEETING.

The annual meeting of the Victorian Branch of the British Medical Association and of the Medical Society of Victoria was held at the Royal Australasian College of Surgeons, Spring Street, Melbourne, on December 2, 1942, Dr. H. BOYD GRAHAM, D.S.O., M.C., the President, in the chair.

DEATH OF MEMBERS ON ACTIVE SERVICE AND MEMBERS REPORTED MISSING.

The Medical Secretary read the names of members of the Branch who had died on active service since the outbreak of war, members standing in silence as a tribute to their memory. He also read the names of those who had been reported missing.

ELECTION OF OFFICE BEARERS AND MEMBERS OF COUNCIL.

The Medical Secretary announced that the Council had elected the following office bearers.

President: Dr. J. A. Cahill.

Senior Vice-President: Dr. David Roseby.

Junior Vice-President: Dr. John Dale.

Chairman of Council: Dr. H. C. Colville.

Honorary Treasurer: Dr. C. H. Mollison.

Honorary Secretary: Professor R. Marshall Allan.

Honorary Librarian: Dr. R. H. Fetherston.

The Medical Secretary announced that the following had been elected members of the Council by the general body of the members: Professor R. Marshall Allan, Dr. Arthur Brown, Dr. Charles Byrne, Dr. H. C. Colville, Dr. John Dale, Dr. D. M. Embelton, Dr. John H. Gowland, Dr. John S. Green, Dr. E. I. Littlejohn, Dr. F. Kingsley Norris (Australian Imperial Force), Dr. David Roseby, Dr. Kenneth Smith, Dr. D. J. Thomas (Australian Imperial Force).

The Medical Secretary announced that the following had been elected by the subdivisions: Dr. H. Boyd Graham, Dr. Henry Searby, Dr. Guy Springthorpe, Dr. J. A. Cahill, Dr. F. McAree, Dr. Roy Watson, Dr. E. M. Ettelson, Dr. L. A. Neal, Dr. M. H. Box, Dr. B. D. Fethers, Dr. F. J. Bonnin, Dr. R. B. Knox, Dr. G. V. Davies, Dr. W. E. Harrison, Dr. F. W. Grutzner, Dr. D. Carter, Dr. W. Sloss, Dr. J. H. Paterson.

The Medical Secretary announced that Dr. F. L. Davies, Dr. R. H. Fetherston, Dr. C. H. Mollison and Dr. J. Newman Morris were the *ex-officio* members of the Council.

The representative of the Victorian Medical Women's Society was Dr. Eileen Fitzgerald and the Director of the Australasian Medical Publishing Company Limited was Dr. J. P. Major.

ANNUAL REPORT OF THE COUNCIL.

On the motion of Dr. Gerald Weigall, seconded by Dr. L. S. Latham, the report of the Council which had been circulated among members was received and adopted. The report is as follows.

The Council of the Branch and the Committee of the Society present the sixty-third annual report of the Branch and the eighty-seventh of the Society.

In accord with the wishes of the Commonwealth Government for the observance of economy and to conserve paper, this report, compared with those of former years, has been abbreviated, although the work of the subcommittees and sections continued during the year.

Election.

At the annual meeting held last December the following members of the Council and of the Committee were elected: Professor R. Marshall Allan, Dr. Arthur Brown, Dr. Charles Byrne, Dr. H. C. Colville, Dr. John Dale, Dr. D. M. Embelton, Dr. John H. Gowland, Dr. John S. Green, Dr. Euan I. Littlejohn, Professor P. MacCallum, Dr. F. Kingsley Norris, Dr. David Roseby, Dr. Kenneth Smith and Dr. Douglas Thomas.

The following were elected to represent the subdivisions: Dr. F. J. Bonnin, Dr. M. H. Box, Dr. J. A. Cahill, Dr. D. A. Carter, Dr. A. E. Coates, Dr. E. Ettelson, Dr. B. D. Fethers, Dr. P. Goodman, Dr. H. Boyd Graham, Dr. F. W. Grutzner,

Dr. D. C. Lear, Dr. F. E. McAree, Dr. J. H. Paterson, Dr. C. H. C. Searby, Dr. W. Sloss, Dr. E. C. Varley, Dr. G. A. Waterhouse and Dr. Roy Watson.

Under Rule 9 the Council elected Dr. Eileen Fitzgerald, nominated by the Victorian Medical Women's Society.

The following are *ex officio* members: the Trustees of the Medical Society of Victoria, Dr. F. L. Davies, Dr. R. H. Fetherston, Dr. C. H. Mollison and Dr. J. Newman Morris, and the representative of the Australasian Medical Publishing Company Limited, Dr. J. P. Major.

During the year the Council coopted Dr. W. D. G. Upjohn a member, and appointed Dr. L. Neal representative of the Northern Suburban Subdivision vice Dr. D. C. Lear, and Dr. J. LeM. Kneebone representative of the South-Western Country Subdivision vice Dr. E. C. Varley.

The Council elected the following office bearers: **President**, Dr. H. Boyd Graham; **Vice-Presidents**, Dr. J. A. Cahill and Dr. David Roseby; **Chairman of Council**, Dr. H. C. Colville; **Honorary Secretary**, Professor R. Marshall Allan; **Honorary Treasurer**, Dr. C. H. Mollison; **Honorary Librarian**, Dr. R. H. Fetherston.

The Executive consisted of the President and other office bearers.

Attendances at Council Meetings.

Eleven ordinary meetings and two special meetings of the Council were held. The following shows the attendances:

Dr. E. Ettelson 13	Dr. J. Newman Morris .. 8
Dr. H. Boyd Graham .. 13	Dr. Eileen Fitzgerald .. 7
Dr. R. Watson 13	Dr. E. I. Littlejohn .. 7
Dr. C. Byrne 12	Dr. C. E. McAree .. 7
Dr. H. C. Colville .. 12	Dr. P. Goodman .. 6
Dr. F. L. Davies .. 12	Dr. J. H. Paterson .. 6
Professor R. Marshall Allan .. 11	Dr. L. Neal ¹ .. 6
Dr. M. H. Box 11	Dr. G. A. Waterhouse .. 5
Dr. J. A. Cahill .. 11	Professor P. MacCallum .. 4
Dr. D. A. Carter .. 11	Dr. W. D. G. Upjohn .. 4
Dr. J. H. Gowland .. 11	Dr. C. H. C. Searby .. 3
Dr. D. Roseby .. 11	Dr. D. C. Lear ² .. 2
Dr. A. Brown .. 10	Dr. W. Sloss .. 1
Dr. D. M. Embelton .. 10	Dr. F. J. Bonnin .. 0
Dr. R. H. Fetherston .. 10	Dr. A. E. Coates ³ .. 0
Dr. C. H. Mollison .. 10	Dr. F. W. Grutzner .. 0
Dr. K. Smith 10	Dr. J. P. Major ³ .. 0
Dr. J. Dale 9	Dr. J. LeM. Kneebone ³ .. 0
Dr. B. D. Fethers .. 9	Dr. D. J. Thomas ³ .. 0
Dr. J. S. Green .. 9	Dr. Kingsley Norris ³ .. 0
	Dr. E. C. Varley ³ .. 0

The highest attendance at any one meeting was 27, and the average attendance was 22.

Appointment of Subcommittees.

The following subcommittees were appointed by the Council (the first-named acting as convener of the subcommittee):

Ethics.—Dr. Davies, Dr. Green, Dr. Morris, Dr. Smith, Dr. Watson and the Executive.

Finance, House and Library.—Dr. Mollison, Dr. Fetherston and Dr. Smith.

Legislative.—Dr. Roseby, Dr. Colville, Dr. Dale, Dr. Davies, Dr. Gowland, Dr. Green, Dr. Littlejohn, Dr. Graham and Professor Marshall Allan.

Organization.—Dr. Roseby, Dr. Cahill, Dr. Box, Dr. Byrne, Dr. Dale, Dr. Fethers, Dr. Fitzgerald, Dr. Gowland, Dr. Graham, Dr. Green, Dr. Ettelson, Dr. Lear, Dr. Littlejohn, Dr. McAree, Dr. Smith, Dr. Watson, Professor Marshall Allan and representatives of country subdivisions. (Dr. Neal was appointed vice Dr. Lear.)

Science.—Professor MacCallum, Professor Marshall Allan, Dr. Graham, Dr. McAree and Dr. Searby.

Hospital.—Dr. Graham, Dr. Colville, Dr. Embelton, Dr. Ettelson, Dr. Smith and Professor Marshall Allan.

Correspondence.—Professor Marshall Allan and Dr. Colville.

Workers' Compensation.—Dr. Byrne, Dr. Colville, Dr. Gowland, Dr. Roseby and Dr. Searby.

War Emergency.—Dr. Cahill, Dr. Gowland, Dr. Littlejohn, Dr. Lear and Dr. McAree. (Dr. Neal was appointed vice Dr. Lear.)

¹ Australian Imperial Force.

² Resigned on appointment to Australian Military Forces.

³ Appointed during the year.

Branch Convocation.

Convocation did not meet during the year.

Membership Roll.

The number of members on the roll at October 31, 1942, was 1,537, which is 70 more than last year. One hundred and twenty names were added (93 by election, 15 who paid arrears, and 12 by transfers into the Branch) and 50 were removed (25 by death, 4 by resignation, 11 by transfer out of the Branch, and 10 who allowed their subscription to fall into arrears).

Honorary medical members now number 39, three having been added and three having died.

Honorary student associates number four.

Provisional members number seven.

Death of the following members and former members is recorded with regret: Dr. G. R. Baldwin, Dr. F. G. Bennett, Dr. J. A. Bissett, Dr. J. P. M. Black, Dr. A. A. Crooke, Dr. M. C. Davies, Dr. Constance Ellis, Dr. C. N. Finn, Dr. Leslie Griffiths, Dr. E. M. Hall, Dr. M. Talbot Hamilton, Dr. E. B. Heffernan, Dr. J. T. Hollow, Dr. W. Kent Hughes, Dr. L. F. Keipert, Dr. G. J. Ley, Dr. H. G. Loughran, Dr. M. Lynch, Dr. M. P. MacGillivuddy, Dr. W. J. Penfold, Dr. W. F. Straede, Dr. J. McN. Scott, Dr. Jas. L. Thompson, Dr. D. Trumpy, Dr. W. B. Vance and Dr. B. Wood.

Roll of Honour.**Died on Service.**

Major Eric Ballhache, Major J. F. Chambers, Lieutenant-Colonel Eric Cooper, Captain J. C. R. Joyce, Captain G. L. Lindon, Major Z. Schwartz, Captain D. J. Shale, Flight-Lieutenant Stuart Thomson, Captain S. I. Weir.

Missing on Service.

Captain C. S. Donald, Surgeon Commander J. R. Hasker, Surgeon Lieutenant-Commander F. H. Genge, Surgeon Lieutenant W. J. McLaren-Robinson, Captain J. F. Park, Surgeon Lieutenant-Commander E. M. Tymms.

Believed to be Prisoners of War.

Major J. F. Akeroyd, Captain B. H. Anderson, Major H. L. Andrews, Captain V. Brand, Captain V. G. Bristow, Major K. B. Burnside, Captain J. F. J. Cade, Captain F. J. Cahill, Major I. T. Cameron, Captain J. P. Catchlove, Lieutenant-Colonel A. E. Coates, Major T. P. Crankshaw, Colonel A. P. Derham, Major E. E. Dunlop, Lieutenant-Colonel N. Eade, Major H. H. Eddey, Captain J. L. Frew, Major R. B. Maynard, Captain P. N. O'Donnell, Major R. G. Orr, Lieutenant-Colonel C. H. Osborn, Colonel D. C. Pigdon, Major H. A. Phillips, Major J. J. Searby, Captain H. N. Silverman, Lieutenant-Colonel H. F. Summons, Captain H. F. Tucker, Captain F. R. Vincent, Major H. A. W. Watson, Colonel E. R. White, Lieutenant-Colonel J. Glyn White, Captain M. F. A. Woodruff.

Honours Conferred by His Majesty the King for Services Rendered during the Present War.

C.B.E.: Colonel H. C. Disher, Brigadier W. W. S. Johnstone, D.S.O., M.C., and Colonel N. L. Speirs.

D.S.O.: Colonel F. K. Norris and Major F. Douglas Stephens.

O.B.E.: Colonel C. W. B. Littlejohn, M.C., and Lieutenant-Colonel J. Glyn White.

M.B.E.: Lieutenant-Colonel J. O. Smith and Lieutenant-Colonel Ian Wood.

D.S.O.: Surgeon Lieutenant E. M. Tymms.

Scientific Distinctions.

F.R.S.: Dr. F. M. Burnet and Colonel N. H. Fairley.

F.R.C.P.: Dr. R. A. Willis and Professor F. L. Apperly.

Meetings of the Branch.

Since the beginning of the year the lecture room at the Medical Society Hall has been occupied by the book and sewing sections of the Red Cross Society, and Branch meetings have been held at the Royal Australasian College of Surgeons. The Branch Council expresses its gratitude to the Council of the College for its generosity in making the lecture hall of the College available for meetings of the Branch.

August.—A symposium on "Lymphogranuloma Inguinale", at which the speakers were Dr. H. F. Bettinger, Lieutenant-Colonel W. C. McCally (U.S.A.S.O.S.), Captain F. McDonald (U.S.A.S.O.S.) and Lieutenant H. Johnson (U.S.A.S.O.S.).

September.—"Foodstuffs and Feeding", by Colonel Sir Stanton Hicks.

October.—The Ninth Sir Richard Stawell Oration: "The Principles of Nerve Surgery as Taught by Research in Nerve Regeneration", by Dr. Basil Kilvington.

November.—The Fourth Embley Memorial Lecture: "Anæsthesia in Military Hospitals", by Lieutenant-Colonel W. B. Parsons (U.S.A.S.O.S.).

Business of Council.

The most important matters considered by the Council during the year were as follows:

The rules of the Branch were consolidated and reprinted and a copy forwarded to every member.

Throughout the year the Council has, at each monthly meeting, discussed the question of the provision of medical personnel for the Forces and has worked in close association with the Victorian Medical Coordination Committee. Following the appointment of Dr. W. D. G. Upjohn as Executive Officer of the Victorian Medical Coordination Committee, he was coopted a member of Council.

With the establishment of the Emergency Civil Medical Practitioner Service, steps were taken to prepare lists of doctors who could most readily be spared from civil practice for emergency duty, and the preparation of the lists was undertaken by meetings of members held in each metropolitan subdivision.

During the year, passes to facilitate the movements of doctors in an emergency were issued with the authority of the State Emergency Services.

Following a conference with representatives of the Pharmaceutical Society regarding the medical and pharmaceutical care of evacuated children, direct representation was sought and obtained on the Medical and Hospital Services Committee of the State Emergency Services by the appointment of the President to the committee.

Further representations have been made to the Charities Board urging the establishment of a central bureau to facilitate admission of patients to hospitals.

On the arrival in Victoria of medical officers of the United States Army, they were offered the facilities of the Branch.

The proposals of the Federal Council for a general medical service for Australia (published in *THE MEDICAL JOURNAL OF AUSTRALIA*, November 1, 1941) and of the National Health and Medical Research Council for the establishment of a salaried medical service (published in *THE MEDICAL JOURNAL OF AUSTRALIA*, August 16 and December 20, 1941) are under consideration.

A subcommittee of the Council has also prepared a report (published in *THE MEDICAL JOURNAL OF AUSTRALIA*, December 13, 1941) on the same subject.

After long delay, the Prices Commissioner advised that he would approve the proposal of the Friendly Societies Association that any increase of the lodge capitation rate should be determined by a member of the judiciary, assisted by ten assessors representing the British Medical Association and the Friendly Societies Association. As the proposal was regarded as impracticable, it was rejected, and an account of the history of the negotiations will shortly be published in *THE MEDICAL JOURNAL OF AUSTRALIA*.

The friendly societies have consented to preserve intact, as far as possible, the lodge lists of doctors on service.

It has been recommended to members that, on production of proof, recipients of old-age and invalid pensions be charged a cash fee of 5s. per visit.

Council has been seriously concerned at criticism, both justified and unjustified, of medical certificates and has informed employers and others that in many cases demands for certificates are unwarranted and evidence required from claimants for sick pay could be better obtained in the form of statutory declarations from the persons concerned.

Following representations from several members, Council agreed to recommend to members the use of a standard form of certificate to cover absence from work. The form decided upon was set out in the notice paper for the general Branch meeting on October 7, 1942.

Through a subcommittee recognized by the Liquid Fuel Control Board, many recommendations for necessary variations in the petrol rations of members have been made.

At the request of the Australian Broadcasting Commission, Dr. H. Boyd Graham was appointed to represent the Branch on the committee responsible for the now well-known series of daily talks, "The Kitchen Front".

During the year Council elected as "provisional members" some of those holding licences under the provisions of the National Security (Alien Doctors) Regulations. Such "provisional members" receive the journals and are entitled to

attend Branch meetings without the right of voting, and their membership will cease when their licences terminate.

During the year the United Friendly Societies Institute at Bendigo was closed.

Council decided that no person formerly holding an unethical appointment should be elected for at least two years after relinquishing such an appointment, and that the subdivision or subdivisions concerned would be consulted before proceeding with his election.

Federal Council.

The Federal Council met in September. A full report of the proceedings appeared in THE MEDICAL JOURNAL OF AUSTRALIA of November 14, 1942, page 437.

The Branch Council entertained members of the Federal Council at luncheon during the meeting.

The Library of the Medical Society of Victoria.

Despite the absence of many members on service, the library has been in constant use throughout the year. The medical officers of the United States Army, stationed in Victoria, have been welcome visitors.

Members of the Library Advisory Subcommittee are thanked for their valuable assistance in the selection of new books.

Presentations to the library during the year have been made by the following, to whom our thanks are tendered: Lieutenant-Colonel H. Brown (U.S.A.S.O.S.), Major Mary Thornton, Dr. S. F. Ridley, Dr. Frank Trinca, and the Editor of THE MEDICAL JOURNAL OF AUSTRALIA.

R. H. ETHERSTON,
Honorary Librarian.

The Income Insurance Fund.

The Income Insurance Fund has continued to render assistance to contributors engaged in full-time service with the Forces, who have suffered a loss of income on relinquishment of practice.

The credit balance of the fund is now substantial, and, as the Trustees expect that the amount in hand will be sufficient to meet anticipated applications for assistance, they propose, next year, to reduce the rate of contribution of those applying for such reduction.

Victorian Medical Benevolent Association.

At the annual meeting of the Association held on March 18, 1942, the audited balance sheet showed:

INCOME.		EXPENDITURE.	
	£ s. d.		£ s. d.
Ordinary subscrip- tions	171 11 9	Account Fee	4 4 0
Special Donations . .	17 17 0	Postages, etc. . . .	2 0 0
Interest on Invest- ments	340 7 3	Bank Charges and Exchange on Cheques	2 15 0
Deficiency for year . .	40 13 0	Payments in Relief . .	561 10 0
	£570 9 0		£570 9 0

Statement of Funds and Investments as at December 31, 1941.

	£
Australian Consolidated Treasury Bonds	2,660
Australian Consolidated Inscribed Stock	5,580
Victorian Government 3% Stock	500
Current Account State Savings Bank, less overdraft Commercial Bank	364
Cash in hand	10
	£9,114

The call on the society for the year 1941 was particularly heavy and exceeded the income of 140 13s. This was met from the accumulated credit balances of previous years deposited in the State Savings Bank.

The committee expects that its burdens are likely to be increased in the immediate future and hopes for generous support during the life of members and legacies at their death. The committee also commends to the profession the proposal that, where recognition of services rendered by one member to another is made, it might take the form of a donation to the fund in the name of the member who has rendered service.

EDWARD L. GAULT,
Honorary Secretary.

The British Medical Insurance Company of Victoria Limited.

The British Medical Insurance Company of Victoria Limited earned a net profit of £1,183 for its last financial year ended April 30, 1942. This compares with £1,330 for the previous year. The main cause of the decrease in profit is increased taxation.

The total premium written for the year was £13,213, compared with £13,862 for the previous year. The decrease in volume is accounted for by the reduction of 25% in the motor car premium rates.

During the year the following donations were made:

To the Medical Society of Victoria—		£ s. d.
Books for Library		59 0 5
Cash		480 0 0
Car Attendant		21 15 0
		£560 15 5
Victorian Medical Benevolent Association		£5 5 0
Books for A.A.M.C. (Abroad)		17 13 6
Books for 4th A.G.H. (Abroad)		17 13 6
Subscriptions for Periodicals for Army Units		39 4 6
		£74 11 6

The company has now the following investments:

Australian consolidated loans and war loan	£9,534 0 0
Medical Society of Victoria debentures	£2,600 0 0

The directors wish to record their appreciation of the continued support of members.

C. H. MOLLISON,
Chairman of Directors.

The following report is published on behalf of the Melbourne Permanent Post-Graduate Committee. It was decided that no further courses of post-graduate teaching should be arranged during the course of the war because of the increase in work thrown both on teachers in the public hospitals and on practitioners in general.

E. GRAEME ROBERTSON,
Honorary Secretary.

On behalf of the Council,

H. BOYD GRAHAM, President.
R. MARSHALL ALLAN, Honorary Secretary.
C. H. DICKSON, Medical Secretary.

Public Health.

PARLIAMENTARY JOINT COMMITTEE ON SOCIAL SECURITY.

THE Parliamentary Joint Committee on Social Security was appointed "to inquire into and from time to time report upon ways and means of improving social and living conditions of the people of Australia and of rectifying anomalies in existing legislation". The personnel of the committee is as follows: Mr. H. C. Barnard (Chairman), Senator Cooper (Deputy Chairman), Senator Arnold, Mr. Maurice Blackburn, Colonel R. S. Ryan and the Honourable J. A. Perkins.

In the issues of December 19 and 26, 1942, summaries of some of the evidence given before the committee in Melbourne have been published. In this issue we publish accounts of the evidence given by Mr. W. H. Best, Grand Secretary of the Manchester Unity Order of Oddfellows of Victoria, and Honorary Secretary of the Consultative Committee of the Friendly Societies of Australia, and Mr. J. S. Parker, General Secretary of the Australian Natives' Association of Victoria and Secretary of the Australian Natives' Association Federal Council (Australia).

Mr. W. H. Best, being sworn, made the following statement.

As I previously appeared before this committee, I have little to add to the statement then submitted, except that as the committee is now specially considering the question of medical and hospital benefits, these are services which the friendly societies at present provide for their members and dependants, and any general provision of these benefits by the Government will most certainly affect the societies to a considerable extent.

There is a very definite demand for medical services at a known cost, and especially is that so by those whose incomes are limited, and who have dependants. To the average wage

earner, a long illness, with possibly a more or less expensive operation on either himself or a dependant, becomes a nightmare, unless he has made some provision whereby he is protected as regards the cost of the medical service. The life savings of many have been eaten up in this way, and it should not be possible for a man to be financially crippled owing to a long illness. The friendly societies are practically the only organizations in Australia to make a domiciliary medical service available to their members, and there is little doubt that a large percentage of members join as much to obtain medical benefits as to secure sick pay and other benefits.

The provision of medical services entails a great amount of detail work on the part of the societies in administration, yet no profit whatever is made out of it. The societies merely act as agents, collecting the quarterly fees from the member, and paying over to the doctor and chemist concerned. At the same time, if medical service is taken away from the friendly societies they will undoubtedly be seriously affected. New members will be more difficult to obtain, and it will no doubt be necessary for the societies to extend their activities into other avenues of service.

During the period when the National Health Insurance Bill was under discussion, the friendly societies and the Federal Council of the British Medical Association consulted together with a view to evolving a more extended family medical service to be administered through the friendly societies, which would have brought in the great majority of the wage-earning class throughout Australia, and it was hoped that this would have been further proceeded with, but the outbreak of war and other causes have resulted in no further definite action being taken.

I therefore feel in a somewhat awkward position in speaking for the friendly societies in respect to proposals which will possibly deprive them of a benefit which they have provided to the limits of their capacity for a century past, but which, personally, I feel would confer a great boon on the majority of the people of Australia. We have been unable to meet and confer together on the question of a free medical service, whereby I could have obtained the opinions of other representatives of the societies, so that any opinions I may give must, I think, be regarded as my own personal ones, and not necessarily those of the societies generally.

My experience in more than thirty years of friendly society administration has convinced me of the great desirability of the provision of a complete medical service to all who need it, and without such cost to the individual as would prove a burden to him, or seriously prejudice his finances. The cost must be such as is well within his capacity to pay.

I would favour a free service to all who desired to take advantage of it. In all States but one, the single member pays to his friendly society the same fee as the married member who may have several dependants, thus reducing the average payment per individual beneficiary. A similar principle would apply if a free medical service be instituted. Taxation would be required to pay for it, and such taxation would be levied on everyone according to capacity to pay, and whether they needed the service or not. As in the case of the friendly society, the strong and healthy would assist to provide for the weak and the sick. The burden would be shared more equitably.

Under present conditions friendly society members must be examined before admission and obtain a certificate of good health. Consequently, those most in need of medical services may be unable to secure them except at high cost, or through public hospitals as charity patients.

A complete service, available to all, should do much in a preventive way in reducing the length of sicknesses and bringing them under control before they develop into a more serious or chronic stage. There is little doubt that many people refrain from calling in the doctor until they are actually forced to, by reason of their fear of the cost involved. The preventive effect of a free service would therefore result in savings of cost in various ways. It would reduce illness and get the wage earner back to work again in quicker time.

Should the Government be prepared to adopt a system of free medical service, I would prefer a scheme on a salaried basis such as that proposed by the National Health and Medical Research Council in preference to a *per capita* payment or so much per visit. By the *per capita* system of payment there may be a tendency to compete for patients in the more populated centres, and to possibly obtain a larger list than a doctor can give proper attention to. Our experience in the friendly societies would readily show the disadvantages of payment at so much a visit. Without wishing to reflect on the medical profession, such a system would allow the doctor to make as many visits as he pleased,

he being the sole judge as to what was necessary, and there would be a strong temptation to make entirely unnecessary visits. Further, such a system would considerably increase the administration costs, on account of the detailed records, book-keeping and checking that would be necessary.

The salaried method would also be much more appropriate in the sparsely settled areas, and indeed would probably be the only method whereby the services of a doctor could be obtained.

Whatever scheme may be adopted by the Government, it should be as full and complete as is practicable, including the general practitioner service, *plus* maternity, specialist, consultant, surgical and X-ray service and hospital treatment.

The outline of the scheme given by the National Health and Medical Research Council has a strong appeal. No provision appears to have been made for the supply of medicines required by the patients, and whether this also should be incorporated in the scheme and supplied free of cost would require consideration. The fees paid by friendly society members are for medical attendance and medicine, one portion going to the doctor and the other to the chemist or dispensary. I think that medicine and surgical appliances should be included as part of the medical service.

Provision should also be made for the issue of the necessary certificates required by friendly societies to enable them to pay sick benefits *et cetera* to their members.

Laymen as well as doctors should be appointed to administer any scheme that may be adopted. The advice and technical knowledge of the doctors is necessary, but the proposals have been mainly evolved by medical men, and full control should not be in the hands of the medical profession. The needs of the people should be paramount, and these should be carefully safeguarded in preference to any advantages and benefits that may accrue to doctors working under the scheme.

Hospital Benefits.—Most of the friendly societies now provide hospital benefits of £1 1s., £2 2s. or £3 3s. per week at the choice of the member for himself or his dependants. Experience has shown the need, and a very decided demand, for some form of insurance against hospital costs that may accrue due to the illness of the member or his dependants, quite apart from the costs of medical attendance.

Fees which were originally fixed at 2s. 6d. *per annum* per unit of benefit (£1 1s. per week) have in many cases been found insufficient to meet the claims, and it has been necessary to increase the fees for the second and third unit, more especially in the case of wives, who are by far the worst risks.

Maternity benefits and outdoor patients were not usually provided for originally, but in recent years several societies have extended their benefits in this direction at an increased cost to the subscriber, and have also allowed non-members to contribute for hospital benefits only. Some demand has also been evident for provision of nursing services in the patient's own home, where admission to hospital has not been practicable.

In reply to Colonel Ryan, Mr. Best stated that there were about 600,000 members of friendly societies in Australia, not all being wage earners. In lodge practice patients had free choice of doctor; for example, in an area such as Camberwell there would be nineteen or twenty lodge medical officers, and he regarded that right of choice as important. In the metropolitan area doctors were paid £1 per member *per annum*, and, although in certain areas some doctors had too many patients, there were few complaints from members.

A lodge member had continuity of service from his doctor with the right to change his doctor at the end of a quarter.

In the Manchester Unity Independent Order of Oddfellows, with 34,000 members, a member paid 5s. per quarter medical fee, 2s. 6d. or more pharmaceutical fee, and for other benefits the contribution averaged 9d. per week, the total average cost for all benefits being £2 to £3 *per annum*.

He thought that in any system of salaried service, laymen should be on the controlling body which, if comprised exclusively of doctors, might place the interests of doctors first.

Replying to Senator Cooper, the witness explained that no doctors did lodge work exclusively and all had private practices in addition.

The friendly societies did not limit doctors' lists, some doctors having over 1,000 members under their care, but the doctors themselves in some cases were limiting their lists and war conditions had led to refusals to accept new members.

Under a salaried service the friendly societies would lose the medical side of their activities, but he thought they could carry on and provide benefits not provided under a Government scheme. He was of the opinion that medical service, if not free, should be provided at a minimum cost. In the lodge system costs varied and in country districts doctors and chemists were paid more.

The friendly society member was entitled to receive only British Pharmacopœia preparations and had to pay for patent medicines and such drugs as sulphonamides. The witness thought there would be a place for the friendly societies in the administration of any system of medical service.

In its scheme of hospital benefits the Manchester Unity Independent Order of Oddfellows did not provide a maternity benefit, but some societies paid up to £4 4s. for a confinement.

In reply to Senator Arnold, Mr. Best stated that it was only in the Melbourne area that a doctor was unable to accept all the patients who desired his services, and in such cases patients had no option but to accept another doctor, but wives of friendly society members objected if there was no choice of doctor and he considered free choice to be most important.

He did not think that many lodge members made unnecessary demands upon their doctors, but poorer people not in lodges hesitated to call their doctors, and he felt that, with a salaried service, there would be over-demands.

Such a service should be financed by taxation, and he considered that people would not object to being taxed for that purpose. He stated that in friendly societies single and married members paid the same rate and some societies provided specialist services. The Manchester Unity Independent Order of Oddfellows paid ear, nose and throat specialists 1s. *per annum* per member and one such specialist had 14,000 members on his list. The society did not provide dental service, but many dentists offered reduced rates to friendly society members.

Social activities of the society, meetings, dances *et cetera* were well attended.

The witness considered that the Government would miss a golden opportunity if it did not introduce a scheme of unemployment insurance at the present time, when so many people were in employment.

Replying to Mr. Perkins, the witness stated that 600,000 people, mainly in the small income group, were served by friendly societies in Australia. When the National Health and Pensions Insurance Bill was before Parliament, representatives of friendly societies visited Canberra and claimed a share in the administration of the proposed national insurance system.

He had seen Press reports of the Beveridge scheme which he thought would put the friendly societies out of business.

Mr. Best agreed with the Chairman's impression that the societies desired an extension of preventive and curative services on a national basis, and would like to play an important part in any scheme which might be introduced.

Mr. J. S. PARKER, being sworn, made the following statement to the committee.

One of the most disturbing problems today, especially for the working and middle classes, is the cost of the unpredictable serious illnesses, involving consultations, specialists, hospitals, nurses' and surgeons' fees and medicines.

Friendly societies realize that the best family doctor cannot, in these days, keep abreast of medical science. He does, and will continue to provide, one of the greatest services to mankind, but he cannot afford, nor be expected to provide, the necessary laboratory and equipment for specialized services. Specialization is necessary.

The extension of benefits by friendly societies in recent years, although restricted, has clearly shown that the community is willing to pay more for medical care than it does now, if the burden is fairly and evenly distributed, and an efficient and comprehensive service is provided. The demand today is for more preventive medicines, for more public funds for medical education, research hospitals, laboratories and diagnostic services.

The four great essentials of good medical care are: (a) Group medical services, including specialists and hospitals. (b) Preventive medicine. (c) Provision for cost, by regular contributions. (d) Democratic and cooperative control.

It is estimated that in Australia 25% of the eligible population belong to friendly societies. A great number do not join friendly societies, not because the benefits are unattractive, but, unfortunately, their economic position is such that because of seasonal and intermittent employment, they cannot afford the necessary regular contribution.

When it is realized that, according to the 1933 census, 80% of the wage earners in Australia received below the basic wage, it will be realized how vital and necessary it is for organized services, such as friendly societies, to provide to the fullest possible extent for the medical care and treatment of the people. Therefore upon the friendly societies has been placed a serious and grave responsibility for the safeguarding of the nation's health. Friendly societies provide the only means by which the majority of the Australian public may obtain security for medical costs.

Medical, hospital and sickness expenses do either of two things: (i) They smash the family savings and security; or (ii) fear makes the family put off vital and necessary advice and treatment until it is too late. It has been well said that man may make some provision against a shower, but not against a cloud-burst. It is a striking reflection upon our nation that the education of a boy or girl may be ruined, the purchase of a home or farm sacrificed, because of a sudden and unexpected illness, involving medical and hospital costs, against which the individual has not had the opportunity of making adequate provision.

In all walks of life it has been demonstrated that whilst an individual may not be able to make provision for his own particular costs, a number of individuals, as a group, may provide against the collective risks of their number. This is the fundamental basis upon which the friendly society movement is based.

Today the friendly societies provide a restricted medical service, limited to medical advice and treatment only, with little or no provision for specialization, X-ray, pathological and other vital services. The provision of medicines is restricted to those drugs which are contained in the British Pharmacopœia, and in few cases indeed are extra services provided.

To a limited extent, hospital benefits have been provided. There has been a most welcome development in the States of New South Wales, Victoria and to a certain extent South Australia in the direction of providing hospital benefits. In Queensland and in a few isolated cases throughout the Commonwealth provision has been made for the actual hospital service and treatment, but these isolated developments indicate that what is possible therein is capable of being effectively provided throughout the whole of Australia.

The postponement of national health insurance legislation has given the friendly societies and the medical profession a valuable breathing space when the whole machinery of social services should be drastically overhauled.

It must be recognized that there has been a serious decline in the scope of service given by the family practitioner as represented by the friendly society medical officer. Consultant and specialized services are vitally essential. Provision should be made for clinical treatment, for example, eyes, ears, nose, throat, skin and dental. Facilities for X ray must be provided. Ambulance service must be made available. The provision of medicines should be brought at least to the basis proposed under national health insurance, namely, the dispensing of prescriptions irrespective of whether drugs and ingredients are included in the British Pharmacopœia or not. The suggested Australian formulary to be arrived at after discussion between the medical profession, chemists and dispensaries and friendly societies appears to be a ready solution.

Friendly society hospitals, established and maintained by the friendly societies, would enable clinical and specialized services to be readily provided, and would do much to retain the friendly society member and his dependants under the control and supervision of his friendly society medical officer, whilst at the same time ensuring the specialized medical and surgical services required.

For people of moderate incomes, the only plan, under existing conditions, is per medium of voluntary health benefits. It is the only method by which the average man can be self-dependent. There is, deeply imbedded in the average Australian, the desire to avoid anything in the nature of charity. Only a realization of the alarming degree to which the provision of the advantages of modern medical science are not being availed of, a critical and decisive examination of the structure of our social services, frank discussion and cooperation with the medical profession, hospital authorities and friendly societies will give the Australian community a service better than that enjoyed today in any other country throughout the world, bring security to the great majority of the Australian public, who obviously cannot individually bear the burden of heavy medical bills, and improve medical care and services beyond anything known today. The health of every individual

belongs not to himself but to the nation. To the medical profession, hospitals and the friendly society movement is given the opportunity of again placing Australia in the forefront of countries throughout the world by a clear and decisive lead in social services.

The Australian Natives' Association has been vitally interested, during its existence of seventy-one years, in the providing of social services for the community. Its policy in respect thereto has been evolved over a long period of years, and is based on its work and experience as a friendly society, and the discussions and deliberations of its members as a national organization.

The Association has viewed with alarm and concern the serious manner in which Australia has lagged behind other nations of the world in the establishing and advancing of its social services.

Members of the community interested in social services and legislation will readily admit that, in Australia, the application and distribution of medical care are lagging considerably behind the science of medicine. The responsibility for this shortcoming must be borne by the medical profession, hospitals and friendly societies, for these are the established institutions capable of giving the community the advantages of modern medical science, but the general position is a grave reflection upon the inability of the respective Governments, both Federal and State, to enable Australia to keep pace with social legislation and the progress accomplished by other nations.

Australia, as a young nation, showed remarkably virility in the latter years of the last century and the early years of this century in the evolving of social legislation, but has now been outstripped by many of the older nations. It is believed that this has been due, to some considerable extent, to the timidity of the Australian Governments to institute new social benefits. There has been too great a tendency to endeavour to copy and imitate the forms of benefit which have been introduced into other countries. An outstanding example is revealed by the failure by the Australian people to enthusiastically endorse and accept the *National Health and Pensions Insurance Act, 1938*.

The legislation was closely modelled upon the English act, and was based upon the reports of experts who did not have a knowledge of Australian life, outlook or conditions. It was a genuine and laudable attempt to introduce advanced social legislation, but the Australian people were already enjoying, through existing organizations, a better service and greater scope of benefit than was proposed in the legislation.

The policy of the Australian Natives' Association, as evolved over a long period of years, affirms and endorses the principle of a complete Commonwealth scheme of national insurance, embracing unemployment, old age, invalidity and health insurance. Failing the adoption of a complete scheme of national insurance, the Australian Natives' Association has affirmed the urgent necessity for the introduction of unemployment insurance, with provisions for other phases of social legislation which are not at present provided through existing institutions. Further, in the introduction of any scheme of health insurance, health benefits should be on a basis of compulsory friendly society membership, with a Government subsidy for those persons unable, because of age or state of health, to join a friendly society under ordinary conditions.

The association, through its branches, its Board of Directors, and its annual conference, discussed from all possible angles the *National Health and Pensions Insurance Act, 1938*, and expressed its strong disapproval thereof, because of its inadequacy in respect to unemployment and its failure to provide a full measure of social benefits. The views and opinions as expressed by members drawn from all phases of community life were that the problem should be grappled with as a whole and complete legislation introduced. Failing such provision, it was felt that each phase of the problem should be dealt with adequately and completely, but that it was a wrong policy to make some further partial provision for some aspects of health and pensions insurance, when the major problem of unemployment was left unsolved. In other words, the problem of unemployment should be dealt with firstly and completely, and when health insurance was contemplated, it again should be dealt with completely, even although it may have to be dissected into: (a) medical services and pharmaceutical benefits, (b) hospital benefits, and (c) sickness benefits.

The association strongly favours complete health insurance, but if this is not possible, the service in respect to each phase of health insurance should be complete. The

1938 legislation failed lamentably, through its non-provision of a family medical service. The legislation provided service for the insured person only, but left to the individual the responsibility of providing medical service for the other members of his family. The average member of the Australian community immediately contrasted this form of service with that which he could obtain from a friendly society, where the medical services for both doctor and medicine are on a family basis. The natural question which arose was: "Why cannot I obtain a complete service for my family?" An insured person who was a member of a friendly society failed to appreciate why he should be making one contribution to compulsory health insurance and still have to make a contribution to a friendly society or similar organization to protect his family.

This legislation is subject to the criticism to which I have referred earlier, namely, it made a limited provision for medical services, and at the same time attempted to embrace pensions and sickness benefits. Its commendable feature was that it provided a complete service in respect to pharmaceutical benefits. It failed entirely to make any provision for specialists' and hospital services. In my opinion it would have been better to have dealt completely with medical, pharmaceutical and hospital services. If it was not possible to have then embraced sickness benefits or pensions benefits, it would have been better to have entirely eliminated these from the legislation, in order to ensure the granting of a complete medical service which would ensure all medical, specialists', pharmaceutical and hospital services.

I desire to direct attention to the Harvelan Oration for 1941, given by Sir Farquhar Buzzard, Professor of Medicine in the University at Oxford. This oration is constructively critical of English social insurance, although he considers that it is difficult to avoid the conviction that in some form of "comprehensive well-organized and perhaps compulsory insurance" a solution may be found. He emphasizes, however, that most provisions are in respect to remedial medicine, and draws attention to the imperative necessity for the developing of preventive medicine.

He states three assumptions: (a) that the preservation of health and the prevention of disability in a community are the highest aims of a medical service, whether looked at from the humane or economic point of view; (b) that the State, in its response to the demand for social services, will not only make increasing provision for the fulfilment of these aims, but will acknowledge the claim of every member of the community when disabled, whatever his means, to the best that the medical profession can offer for his restoration to health; (c) that in cases of serious disability skilled diagnosis and treatment must pass more and more into the hands of specialists and hospitals.

I draw particular attention to, and completely endorse, his claim that every member of the community, irrespective of his financial or economic position, is entitled to the best that the medical profession can offer for restoration to health.

In respect to the provision of unemployment insurance, I believe that the average Australian looks askance at a palliative which is given as a weekly sustenance when he is unemployed, and he would welcome a properly organized basis of national employment, the objective of which would be to ensure regular employment, and not merely to pay a weekly sum during the period he is unemployed. I do not think the prospect of unemployment insurance, as such, will be adequately accepted as a contribution towards national social service, unless the problem is grappled with on the basis of the report of the Royal Commission appointed by the Commonwealth Government, and which dealt exhaustively with this matter in its report in 1927. In fact, I submit that the whole of the reports of the Royal Commission which investigated national insurance at that period, and presented its final report on March 11, 1927, are an admirable basis for discussion of the problem of social insurance in all its phases, and the proposals and recommendations were more adequate, more national, and considerably in advance of the legislation introduced in 1938.

I have referred to the question of social insurance on the principles of compulsory friendly society membership, and have noted with extreme interest the Press references to the Beveridge report submitted this week to the British Parliament.

The outstanding feature, in my opinion, is the recommendation that all salary and wage earners, irrespective of income, shall be included. There is provision for a contribution to be paid by an insured person, which principle I strongly endorse, as it establishes entitlement by right and

establishes self-dependence, and removes the atmosphere of charitable grant. It also establishes the principle of administration by democratic control and removes the difficulties and dangers of bureaucratic control.

Compulsory membership of social service organizations, such as friendly societies, obviates the major difficulties which arise in applying equitably a contributory scheme of social insurance, based on contributions by employer and employee, but it retains essential features of benefits to which the insured person is entitled by his own right.

I am not proposing to discuss the merits of a contributory or non-contributory scheme, but of the scope of service to be provided, both as to benefits and the including of all persons therein.

The 1938 Act.—Taking the *National Health and Pensions Insurance Act, 1938*, as a basis, I desire to point out the tremendous difficulty which arose, and which, in my opinion, made it almost unworkable on a truly national basis.

Self-Employed Persons and Small Employer.—In all schemes of a contributory nature which have been introduced in various countries of the world, there has always been the problem of the self-employed person, the small farmer, persons in casual and intermittent employment, the farmer-orchardist and others similarly engaged, including many who may be employer, employee and self-employed, all within the period of a few months. I refer to farmers with small holdings, who must engage labour for part of a season, but who themselves seek employment at other periods of the year.

Unfair Burden of Employers' Contributions.—There is also the grave disability that the contribution does not fall evenly upon industry. Professional men, such as members of the legal fraternity and the medical profession, may have a large income, but employ practically no labour. By contrast, others may have considerably smaller incomes, but be compelled to engage considerable labour, for example, persons growing vegetables or producers of perishable goods, who engage considerable labour of a casual nature, in order to be able to market their goods. These employers must contribute heavily under a contributory scheme, but receive no benefit themselves, unless they pay the full share of contributions, that is, employer and employee. Other persons who derive income from property, from investments, and from similar sources, would make no direct contribution to a national scheme of social insurance. I realize that some contribution would be made through taxation, but this would also apply to those who have already paid a direct contribution in respect to their own employees.

One outstanding anomaly in the legislation adopted by the Federal Parliament was the failure to make provision for a small employer, such as a boot repairer, grocer, butcher, or other similar essential form of business, where often only one employee was engaged, but the owner of the business had to pay the employer's share for his employee, but was himself denied benefit unless he paid the employer's and the employee's contribution for himself.

Greater Scope of Friendly Society Benefits.—There is also the important factor that friendly society membership gives a number of important benefits not generally provided under national insurance. There is firstly the providing of doctor and medicines for the dependants of an insured person. The *National Health and Pensions Insurance Act, 1938*, provided these benefits for only the insured person. Most friendly societies have established a hospital benefit fund scheme which provides benefits up to £3 3s. per week, whilst a member or dependant is an inmate of any hospital—private, intermediate or public—in the Commonwealth. The providing of this type of benefit has been an interesting experiment and experience. I have no hesitation in saying that, in my opinion, friendly societies have lagged considerably in the extending of their benefits, but this has been largely caused by the uncertainty which exists in respect to governmental proposals. If the societies were satisfied that the Government did not intend to introduce extended schemes of social insurance, I am confident the societies would readily undertake a comprehensive scheme of extended benefits for their own members. Although voluntary schemes of hospital benefits were in force for a number of years, the Australian Natives' Association in Victoria was the first society to introduce a compulsory form of hospital membership. It was welcomed by members, who readily realized the opportunity afforded them to provide, by regular contributions, protection against the costs of hospital services. The fund has been established for eight years, and has now been stabilized on the following basis:

ANNUAL CONTRIBUTIONS IN ADVANCE.		BENEFITS (QUALIFYING PERIOD OF MEMBERSHIP, FIRST UNIT 4 WEEKS, ADDITIONAL UNITS 6 MONTHS).	
Member—			
1 unit (3s.)	£1 1s. per week for 13 weeks in any period of 12 months		
2 units (6s.)	£2 2s. per week for 13 weeks in any period of 12 months		
3 units (9s.)	£3 3s. per week for 13 weeks in any period of 12 months		
Wife—			
1 unit (3s. 6d.)	£1 1s. per week for 13 weeks in any period of 12 months		
2 units (7s.)	£2 2s. per week for 13 weeks in any period of 12 months		
3 units (10s. 6d.)	£3 3s. per week for 13 weeks in any period of 12 months		
Children (Up to 16 Years of Age)—			
1 unit only (2s.)	£1 1s. per week for 13 weeks in any period of 12 months		

NOTE.—Hospital benefit shall not be paid in respect to accouchement or miscarriage nor for any sickness arising out of, or occasioned by, pregnancy, lying-in, miscarriage or any sickness experienced during the first four weeks after childbirth or miscarriage.

Members have unhesitatingly declared their approval of the benefit and it has been remarkably attractive for the securing of new members.

The next logical step would be the establishing of friendly society hospitals for their own members. This has been done in Queensland. In Victoria, societies have not the power under the *Friendly Societies Act* to establish their own hospitals, but have asked the State Government for the necessary amendment of the *Friendly Societies Act* to enable them to do so. If such hospitals were established, possibly a chain of hospitals throughout the metropolitan area, and with special wards attached to existing hospitals in country centres, would be quickly introduced.

Other forms of specialized services, such as X-ray and ophthalmic benefits, would readily follow.

Such a chain of hospitals would enable a member to receive treatment adjacent to his usual place of residence. He could remain reasonably close to his friendly society medical officer, and the societies, with their activities, would doubtless raise considerable sums for establishing necessary additional facilities which would be necessary with the progress of medical science. Home nursing, including attention in the vital ante-operative and post-operative period, would be a natural adjunct.

Funeral benefits have a very definite appeal under friendly society membership. They have been described as the rock of self-help upon which friendly societies were originally established.

The principal extensions and additions to existing friendly society benefits would be the providing of a greater scope of medical services and of medicines. Medical service, in my opinion, should be complete. It should be established on a clinical basis, and should enable the insured person to provide, by regular contribution, for the cost of any surgical operations which may be required. Any impression that the insured person is receiving concessional service should be removed. I am satisfied that the average Australian would welcome the opportunity to provide, by regular contributions, for all medical, specialized and surgical services, medicines and hospital treatment which may be required. It is the only service which gives security to a citizen. I think security should be a predominant feature of any scheme which may be introduced.

Social insurance should not be restricted to the low wage earning group. The great middle classes are fully entitled to security, and I sincerely hope that the blunder of the distinction of those engaged in manual and non-manual labour, as laid down in the *National Health and Pensions Insurance Act, 1938*, will not be allowed to persist.

Apart from the difficulties of the thousands of decisions and interpretations of what is a manual or non-manual labourer, why should there be any distinction between citizens merely because of the nature of their employment? In what way is a person in non-manual labour more able to pay privately for social services than a person engaged in manual labour? The wider scope of service, higher rate of sickness allowance, including the dependants' allowance, which I strongly approve and commend, could be met from taxation, which would be equitably borne by all, and not only by those employing labour, whereby the employer pays according to the number of persons employed, and not upon the income of his business. At the outset, a subsidy would be required in respect to those whose age exceeds the prescribed age of admission to benefit and those who are not

in sound health, but this is a difficulty which must be encountered in introducing any scheme of a nation-wide nature, and the amount of the subsidy would gradually decrease and eventually disappear when all persons were admitted at the age of sixteen or whatever age is determined. Such a scheme would not interfere with pensions or unemployment insurance, which could possibly be administered by joint authority, separate from health insurance.

Replying to Senator Arnold, Mr. Parker said that to finance an extended scheme of health benefits, the Australian Natives' Association favoured a contributory system which gave the contributor a right of which he could not be deprived. Provided direct contributions were made there would be no objection to a graduated tax if the moneys derived from it were specifically set aside.

He maintained that the family practitioner was not giving as complete a service as formerly, as the general practitioner knew the need for specialized treatment and referred his patients to specialists. Doctors could not keep up with medical progress and had not time for post-graduate work.

Members of his Association were asking, in fact demanding, that provision be made for specialist services and for extension of the hospital fund, and were willing to pay for what they wanted.

Queensland was the only State with a complete hospital, Kelvin Hall, controlled by friendly societies, and that institution charged 22s. per week, in addition to a small yearly contribution. At that hospital provision was made for working men to receive treatment on Sundays, and it also provided home nursing before admission to, and after discharge from, hospital. He visualized a chain of ten or twelve hospitals in the Melbourne metropolitan area, equipped with radiological facilities, and adjacent to members' family doctors.

He thought that the basis of any system of social insurance should be provision for complete security and should include funeral benefits.

Replying to Colonel Ryan, Mr. Parker said that, although impressed by it, he found difficulty in reaching a conclusion regarding the scheme of the National Health and Medical Research Council. It seemed to be adapted to group medical service, to which the public would have to be educated, as there was a great deal in personal contact of doctor and patient.

Mr. Parker informed the Chairman that the Australian Natives' Association had 46,000 members in Victoria and 70,000 in Australia, but the New South Wales Branch of the Association did not provide any medical services to its members.

Correspondence.

THE ALLIED WORKS COUNCIL AND CIVILIAN MEDICAL PRACTITIONERS.

SIR: I have just learned with alarm that the Allied Works Council has been invested with power to conscript civilian medical men for whole- or part-time work for supplying the medical needs of their employees; adding insult to injury by offering payment for such services at the rate of 12s. per half-day or part thereof and sixpence a mile mileage!

Surely the Federal Council of the British Medical Association is going to do something mighty quickly to combat this further encroachment on our liberties and gross exploitation of our spirit of sacrifice which has already been strained to the full. We have cheerfully accepted conscription by the Medical Co-ordination Committee, and many of us have given up valuable hours to perform work for the military authorities at a rate of pay which is little more than an honorarium. Others of us have given and are giving up many hours of their time to many quite voluntary works such as hospitals, A.R.P. *et cetera*. But these are all in connexion with our war effort, and as such are done cheerfully and without stint or complaint. The A.W.C. and the C.C.C. on the other hand are not essentially "war efforts" and will not presumably be disbanded when the war is won—indeed they may well be expanded to a far greater extent than is dreamed of now; and this medical service which they so generously offer to their employees may be the foundation of a general salaried medical service. Are we then going to allow ourselves to be conscripted into such a service which places us under lay control, lays down a scale of remunera-

tion lower than that of a skilled tradesman, and for all we know now may prove to be the thin end of the wedge for a nationalized salaried service.

I feel that the threat to our rights is so grave and the incidence under present conditions so insidious, that I take this opportunity of informing the profession as a whole of what is going on in the hope that action may be taken before it is too late.

Yours, etc.,

B. D. FETHERS.

569, North Road,
Ormond,
Victoria.

December 16, 1942.

Naval, Military and Air Force.

APPOINTMENTS.

THE undermentioned appointments, changes *et cetera* have been promulgated in the *Commonwealth of Australia Gazette*, Number 325, of December 17, 1942.

ROYAL AUSTRALIAN AIR FORCE.

Citizen Air Force: Medical Branch.

Squadron Leader J. C. Laver (1199) is granted the acting rank of Wing Commander, whilst occupying a Wing Commander post with effect from 1st October, 1942.

The following is appointed to a commission on probation with the rank of Flight Lieutenant with effect from the date indicated: Loris Phillip Blashki, M.B., B.S. (7136), 12th November, 1942.

The following Flight Lieutenants are transferred from the Reserve with effect from the dates indicated: F. E. Browne (6800), 30th September, 1942; G. F. Saggars (7113), 26th October, 1942.

The following are appointed to commissions on probation with the rank of Flight Lieutenant with effect from the dates indicated: Barry Jarvis, M.B., B.S. (7090), Edward Donough Ernest Eugene O'Brien, M.B., B.S., D.O.M.S., D.O. (7096), 4th November, 1942.

Reserve: Medical Branch.

The following are appointed to commissions on probation with the rank of Flight Lieutenant and with effect from the dates indicated: Donald Dryborough Cunynghame, M.B., B.S. (7084), Rothwell Allan Hill, M.B., B.S. (7085), Joseph Robert Wadsworth, M.B., B.S. (7086), 30th October, 1942; Eric Lloyd Bird, M.B., B.S. (7089), 2nd November, 1942; James Ballard Felstead, M.B., B.S. (7109), Douglas Britton Pearce, M.B., B.S., B.Sc. (7111), Noel Glenn Dobell-Brown, M.B., B.S. (7113), Arthur Kitchener Smith, M.B., B.S. (7110), Jack Henry Palmer Abbott, M.B., B.S. (7131), 11th November, 1942.—(Ex. Min. No. 199—Approved 9th December, 1942.)

The following are appointed to commissions on probation with the rank of Flight Lieutenant with effect from the dates indicated: Robert John Fleming, M.B., B.S. (7137), Peter Alexander Tod, M.B., B.S. (7138), 11th November, 1942; John Thomas Cullen, M.B., B.S. (7165), Charles Rowe, M.B., B.S. (7153), 16th November, 1942.—(Ex. Min. No. 202—Approved 9th December, 1942.)

The following are appointed to commissions on probation with the rank of Flight Lieutenant with effect from 30th October, 1942: Ian Mitford Lilley, M.B., B.S. (7076), John Noel Brown, M.B., B.S. (7083).—(Ex. Min. No. 211—Approved 9th December, 1942.)

CASUALTIES.

ACCORDING to the casualty list received on December 29, 1942, Major H. F. G. McDonald, A.A.M.C., Canterbury, Victoria, is reported to have been killed in action as a result of enemy aircraft action.

Obituary.

JAMES ADAM DICK.

WE regret to announce the death of Dr. James Adam Dick, which occurred on December 23, 1942, at Randwick, New South Wales.

The Royal Australasian College of Physicians.

EXAMINATION FOR MEMBERSHIP.

Provided a sufficient number of candidates is offering and if circumstances permit, an examination for membership of the Royal Australasian College of Physicians will be held in Melbourne in March and April, 1943.

The examination will consist of (i) a paper on the principles and practice of medicine, including pathology, therapeutics and the history of medicine; (ii) an oral examination, which may include the clinical examination of patients, together with the identification of naked-eye and microscopic specimens.

The written paper will be taken in capital cities where candidates are offering on Saturday, March 13, 1943, and the corresponding clinical examination will be conducted in Melbourne on Thursday, April 8, 1943.

Application forms may be obtained from the office of the College, 145, Macquarie Street, Sydney, and should be in the hands of the Acting Honorary Secretary at this address not later than Saturday, February 13, 1943.

Corrigendum.

We regret that some proof corrections made by Dr. E. B. Durie in the paper by her and J. W. Legge were not embodied prior to publication in the issue of December 26, 1942. On page 562 in the second paragraph under "Analytical Methods" the last line should read "at a concentration of 10^{-4} molar in a one centimetre cell". On page 563 in the second column the first sentence of the last paragraph but one should begin: "A further difference between the conditions in the experiments of Selbie . . ." In the equation in the first column of page 564 the Greek letter χ should have been used instead of X . This also applies to the two lines succeeding the equation where X appears.

Nominations and Elections.

THE undermentioned have applied for election as members of the New South Wales Branch of the British Medical Association:

Bishop, Peter Orlebar, M.B., B.S., 1940 (Univ. Sydney) (R.A.N.R.), Flat No. 2, 53, The Esplanade, Balmoral Beach.

Dey, Robert Middleton, M.B., B.S., 1942 (Univ. Sydney), 310, Miller Street, North Sydney.

Medical Appointments.

Dr. Lindon Archdall Langley has been appointed, pursuant to the provisions of the *Lunacy Acts* of Victoria, to be Superintendent (acting) of the Mental Hospital, Ararat, from December 5, 1942.

Under the provisions of the *Medical Practitioners Registration Ordinance*, 1930-1939, Dr. M. J. Holmes, Dr. J. A. James and Dr. F. McCallum have been appointed for a period of three years members of the Medical Board of the Australian Capital Territory.

Under the provisions of the *Nurses Registration Ordinance*, 1933-1941, Dr. M. J. Holmes, Dr. F. McCallum and Dr. C. C. Findlay have been appointed members of the Nurses' Registration Board of the Australian Capital Territory for a period of three years.

Dr. Wilfred Arthur Joseph Brady has been appointed, pursuant to the provisions of the *Lunacy Acts* of Victoria, to be Superintendent (acting) of the Mental Hospital, Beechworth, from December 14, 1942.

Australian Medical Board Proceedings.

SOUTH AUSTRALIA.

THE undermentioned have been registered, pursuant to the provisions of the *Medical Practitioners Act*, 1919-1935, of South Australia, as duly qualified medical practitioners:

Griffiths, William James, M.B., B.S., 1942 (Univ. Sydney), Children's Hospital, Adelaide, South Australia.

Grant, Wemyss Gordon, M.B., B.S., 1924 (Univ. Melbourne), Finsbury, South Australia.

The following additional qualification has been registered:

Finger, Alan Henry (M.B., B.S., 1934, Univ. Melbourne), D.P.H., 1941 (Univ. Sydney), Infectious Diseases Hospital, Northfield, South Australia.

Books Received.

"Disorders of the Blood: Diagnosis, Pathology, Treatment and Technique", by L. E. H. Whitby, C.V.O., M.C., M.A., M.D. (Cantab.), F.R.C.P. (London), D.P.H., and C. J. C. Britton, M.D. (New Zealand), D.P.H.; Fourth Edition; 1942. London: J. and A. Churchill, Limited. 10" x 6", pp. 607, with 71 illustrations, eight of which are in colour. Price: 28s.

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Honorary Secretary, 135, Macquarie Street, Sydney): Australian Natives' Association; Ashfield and District United Friendly Societies' Dispensary; Balmmain United Friendly Societies' Dispensary; Leichhardt and Petersham United Friendly Societies' Dispensary; Manchester Unity Medical and Dispensing Institute, Oxford Street, Sydney; North Sydney Friendly Societies' Dispensary Limited; People's Prudential Assurance Company Limited; Phoenix Mutual Provident Society.

Victorian Branch (Honorary Secretary, Medical Society Hall, East Melbourne): Associated Medical Services Limited; all Institutes or Medical Dispensaries; Australian Prudential Association, Proprietary, Limited; Federated Mutual Medical Benefit Society; Mutual National Provident Club; National Provident Association; Hospital or other appointments outside Victoria.

Queensland Branch (Honorary Secretary, B.M.A. House, 225, Wickham Terrace, Brisbane, B.17): Brisbane Associated Friendly Societies' Medical Institute; Bundaberg Medical Institute. Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

South Australian Branch (Honorary Secretary, 178, North Terrace, Adelaide): All Lodge appointments in South Australia; all Contract Practice appointments in South Australia.

Western Australian Branch (Honorary Secretary, 205, Saint George's Terrace, Perth): Wiluna Hospital; all Contract Practice appointments in Western Australia.

Editorial Notices.

MANUSCRIPTS forwarded to the office of this journal cannot under any circumstances be returned. Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary be stated.

All communications should be addressed to the Editor, THE MEDICAL JOURNAL OF AUSTRALIA, The Printing House, Seamer Street, Glebe, New South Wales. (Telephones: MW 2651-2.)

Members and subscribers are requested to notify the Manager, THE MEDICAL JOURNAL OF AUSTRALIA, Seamer Street, Glebe, New South Wales, without delay, of any irregularity in the delivery of this journal. The management cannot accept any responsibility unless such a notification is received within one month.

SUBSCRIPTION RATES.—Medical students and others not receiving THE MEDICAL JOURNAL OF AUSTRALIA in virtue of membership of the Branches of the British Medical Association in the Commonwealth can become subscribers to the journal by applying to the Manager or through the usual agents and booksellers. Subscriptions can commence at the beginning of any quarter and are renewable on December 31. The rates are £3 for Australia and £2 5s. abroad per annum payable in advance.